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CATASTROPHIC CARE—EXCESS REVENUES

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

JUNE 1, 1989

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CATASTROPHIC CARE—EXCESS REVENUES

THURSDAY, JUNE 1, 1989

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:30 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Moynihan, Baucus, Boren, Bradley, Mitchell, Pryor, Riegel, Rockefeller, Daschle, Packwood, Roth, Danforth, Chafee, Heinz, and Durenberger.

[The press release announcing the hearing follows:]

[Press Release H-29, May 23, 1989]

SENATOR BENTSEN ANNOUNCES HEARING ON CATASTROPHIC CARE EXCESS SURPLUS

WASHINGTON, DC—Senator Lloyd Bentsen (D., Texas), Chairman, announced Wednesday that the Finance Committee will hold a hearing on the treatment of excess revenues that are expected under the Catastrophic Coverage Act enacted last year.

The hearing will be held on Thursday, June 1, 1989 at 9:30 a.m. in Room SD-215 of the Dirksen Senate Office Building.

"I've called this hearing to focus on those circumstances that have changed since the legislation was enacted, in particular the mistake by the government technicians in the earlier cost/benefit estimates of the legislation," Bentsen said.

"The method of financing Medicare benefits has been the subject of intense debate for months. On the benefits side, though, the complaints I've heard have been that the bill doesn't go far enough," Bentsen said.

"As I indicated on April 20, I'm concerned about estimates that show we'll have an excess surplus. Treasury, the Joint Tax Committee and the Congressional Budget Office all tell us that the surplus is going to be bigger than we originally expected, although Congress and the Executive branch agencies differ on the size of the excess," Bentsen said.

"When the legislation was enacted, we built in a cushion to allow for a reserve against unanticipated costs. Now we need to decide what to do with the excess surplus we're apparently accumulating," Bentsen said.

"I remain convinced that this program is a good one, and it will help ensure that older Americans who face medical catastrophe won't face financial ruin as well," Bentsen said.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, SENATE FINANCE COMMITTEE

The CHAIRMAN. This hearing will come to order. The subject of today's hearings is the financing of expanded Medicare benefits made available under last year's catastrophic bill. The fact that the potenqtial beneficiaries of the catastrophic insurance program paid the premiums, as recommended by President Reagan and approved by the Congress, has become a subject of controversy and so has the combination of a flat premium and an income-related supplemental premium. A touch of means testing. That was also passed by the Congress and approved by President Reagan.

Now I assume that the benefits offered by the legislation are widely supported, since the benefit-related complaints that I have heard thus far are that they do not go far enough. As the new catastrophic benefits have only become available in the last 4 months, with major new benefits phased in over the next few years, I expect public support for this program to continue to grow.

Now the witnesses that we have, particularly as I look at some of the members of Congress that are going to be testifying, I am sure will range beyond the principle subject of hearings this morning and that is well and good. I think it is important to recall how long we have had hearings on this particular piece of legislation. And the two bodies, they stretched over 2 years. In fact, back in 1984, I held some of the first hearings on it in the Joint Economic Committee. We have had a great number of interest groups that have put across their points of views and those were considered as we put this piece of legislation together.

But as I indicated on April 20, I am concerned about the new estimates of the revenue generated by the supplemental premium. Treasury, Joint Tax, CBO, all tell us that the revenue from the supplemental program, those premiums, are going to be higher than they anticipated. Over the period of 1989 to 1993, premium revenues are now expected to exceed the projected needs of the Medicare catastrophic benefits by $9.1 billion.

Now when that bill was signed into law, we built in a reserve, and I am talking about an excess reserve, a reserve above those reserves that were committed to pay the benefits as they would have been anticipated. We built in a cushion of $4.2 billion, trying to be prudent, trying to be careful, trying to be certain we had enough money there. Because in any insurance program, catastrophic premiums were intentionally set somewhat higher than was necessary, or expected to be necessary to pay the benefits.

Under Joint Tax Committee and Congressional Budget Office projections we are now faced with an unexpected windfall of $3.8 billion over and above the cushion of $4.2 billion reserve we set out to create.

Now that kind of an increase and that kind of an excess cushion, or reserve, is the subject of our hearings. What is the appropriate treatment of the excess revenues we are apparently facing? We will hear from the administration that the excess should be used to build a more generous reserve fund in case costs are far higher than expected. And others may wish to reduce the future premiums. Some might feel that that excess money should be dedicated to specific interest groups to reflect their concerns for the legislation, who might feel that they are unfairly treated in the legislation. And finally, I have even heard some talking about expanding the benefits where they are now.

I think it is critical that we get input from consumer groups, from the administration, as we consider the next appropriate step.

I want to say a word about one option for dealing with the excess revenues that I expect will be the option advanced by the Assistant Secretary of the Treasury, Mr. Wilkins. The administration is already on record as opposing any changes in the catastrophic benefits or the financing. They believe that there's enough uncertainty about the cost of the new benefits, especially prescription drugs, that we need to hold onto any excess revenues to make sure we can pay the bills.

Now let me say, I am as concerned as anyone else on that one. I want to be sure that those prescription drug benefits are adequately financed. I am generally pretty cautious about these kinds of matters and I am more than a little familiar with the principles of insurance. I insisted on phasing in those benefits to allow for the course corrections, to take care of errors unanticipated and in estimating the costs of the complexity of the regulations and implementation.

I strongly supported President Reagan when he insisted that the reserve margins be as high as 75 percent or 175 percent of total reserves, that that be built in the program in the first few years. I supported giving the administration flexibility to defer implementation of drug benefits if cost projections were exceeded. I supported a separate drug trust fund and the creation of a permanent Commission with Alice Revlin at the helm to examine the cost issues over time.

I supported the law's requirement for extensive data reporting so that we could keep a handle on the new benefit. And along with many of my colleagues, I listened to the Medicare actuary and CBO discuss their differing estimates of prescription drug costs before this Committee in June of 1987.

Prudence, however, if taken too far can cause paralysis. I believe we may be approaching excessive caution to accumulate reserves that are 133 percent of average annual outlays.

The one thing I do not want to see happen—I do not want to see us take the idea of a user fee, in effect a premium for the beneficiaries, and see it treated like we have seen the highway trust fund treated, where we have collected an excess in those user fees, put it there and then not used it for the purpose for which it was intended, and used it to help balance the budget.

I do not want to see us do it like we have seen done on the airport trust fund, where we have charged users a fee and then not spent it to modernize the airways, to put in the additional navigational equipment.

In other words, I do not want to see the budget balanced with an excess collection on the backs of the senior citizens. I do not want to take this beyond what the intent and the objective was.

Now we have a great number of witnesses this morning. We will have supplemental appropriations on the floor and interruptions for votes. We have quite a number of members of the Senate and the House who want to testify. I want to ask that my colleagues keep their opening statements to 3 minutes, after the ranking member has a chance to say his piece.

Senator PACKWOOD. I will say mine in 3 minutes, Mr. Chairman.

The CHAIRMAN. All right. Then I want all witnesses, with the exclusion of the Secretary, who as I understand it has a commitment on the West Coast and we are most appreciative of having you, but all of them to hold their statements to 5 minutes at the maximum—not because we are trying to limit you, but because we have so many interested witnesses we want to hear from—and I anticipate we will be going on into the afternoon with special permission of the Senate for us to meet.

I now defer to the ranking member.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. Well, Mr. Chairman, I do not understand why we are in such a swivet about the amount of 5-year reserves. The Joint Committee on Taxation estimated we would raise $35 billion over the 5 years of this program- -and that we would have a $4 billion surplus. Now they estimate the administration will raise about $39 billion—$4 billion more—so we will have $8 billion in the reserves instead of $4 billion.

That, to me, does not seem to be excessively conservative. Secondly, I have never seen a medical program that the Government gets into that costs as little as we thought it was going to cost when we got into it. So I am not at all hesitant to say, let us err on the cautious side and have this reserve a bit bigger than we initially planned because the cost may be a bit bigger than originally planned.

The second issue is whether or not to have the benefits of the Catastrophic Act. I hope, if we have the benefits, we do ask the beneficiaries to pay for them. If we want to cut back on them, if we want to change them, if we want to eliminate the drug benefit, those are all matters of fair debate. If we do that, we could cut back on the premium.

But I really think we are making a mountain out of a mole hill if we are going to keep all of these benefits. That is, I have a problem with the following line of reasoning: the benefits are not going to change an iota from what we predicted, but—because we are now going to raise $4 billion more than we thought over the next 5 years—let us cut back the taxes $4 billion. This assumes too much faith in the accuracy of 5-year predictions for a new health benefit. I fear what will happen is we will end up putting the taxes back in in 2 or 3 years, or worse, we will start taking it out of the general fund.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

The arrival list is Moynihan, Pryor, Baucus, Durenberger, Packwood, Boren, Heinz and Chafee.

Senator Moynihan.

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. Mr. Chairman, you have led this Committee in this matter for the longest while now and you will continue to do so as far as this Senator is concerned. I want to thank you for holding this hearing and for setting for the issues as you have done.

Might I just add one point to your point, which is that with respect to the testimony we shall hear from the Treasury, which is that increasingly we are seeing a pattern in this Government of financing the general expenditures of Government with revenues from social insurance trust funds. The Society Security Trust Funds, old-age survivors and disability, are rising at $1 billion a week. That $1 billion a week is not being saved for the purpose in which it is held in trust, but is being spent for general purposes of government.

Increasingly, we are financing Government with the most regressive of taxes which happen also to go to something called trust funds. So I don't think, sir, that we are keeping that trust very well.

I thank you.

The CHAIRMAN. Thank you.

Senator Pryor.

OPENING STATEMENT OF HON. DAVID PRYOR, A U.S. SENATOR FROM ARKANSAS

Senator PRYOR. Yes, Mr. Chairman, I, too, want to thank you for holding this hearing. At each town meeting we go to, generally the first question we get relates to this issue of catastrophic health insurance and the supplemental premium.

The two or three issues I'd like to touch on, Mr. Chairman, deal with the issue that you so eloquently raised with the President and that is the excess revenues that apparently we are collecting at this time. If we think people are concerned or mad about a certain section of catastrophic health insurance now, we have not even seen the beginning of that anger.

If they feel that this particular section of catastrophic health insurance is going to be utilized to balance the budget or reduce the deficit, I think that we are going to continue seeing a fire storm and we are going to continue loosing credibility on this particular issue.

Mr. Chairman, I would like to raise the issue of drug utilization review. I would, if I might, ask my colleagues' unanimous consent to submit a GAO report that I am releasing today relating to the drug utilization review issue. The bottom line of this report is that HCFA can now patch in existing systems and not have to reinvent the wheel and go out and find new systems to implement the drug utilization review provisions of the new law. According to GAO, we have sufficient systems to patch in to existing systems today.

I hope the distinguished Secretary will take this GAO report into consideration.

Mr. Chairman, the other issues that I will discuss are going to be included in my statement. I think my time has expired. I yield back the balance of my time and ask unanimous consent that my full statement be placed in the record.

The CHAIRMAN. Without objection. That will be done.

[The GAO report appears in the appendix.]

The CHAIRMAN. Senator Baucus.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Mr. Chairman, I think all of us very much thank you for holding these hearings. As Senator Pryor said, there are not many town meetings when this question does not arise. In fact, I could say in my State of Montana that at every single town meeting, not one, not two, but several people have asked me, "Now what about this catastrophic program? Why are we paying for it? What is going on here?"

The basic problems as I see it, as people see it, are these: Many people are asking why am I forced to pay for this program. Some of these are retired Federal employees, some are persons with other health insurance programs. A lot of people are wondering why are they forced to comply with a program that they do not want to be part of. That is one general set of complaints I hear.

A second is: Why does it cost so much? Of course, these are people who are upper income people—have more income than some others. But that tends to be the second set of questions that I hear most frequently. Why does this cost me so much? Why so many hundreds of dollars when I have some other program and so forth?

Now an earlier version of our Senate Catastrophic bill was optional. Maybe this should be optional—supplemental health insurance—Part B premiums are optional. If seniors have a choice to participate under Part B, maybe they should have the option to participate under catastrophic. I think that is an issue worth exploring.

Nevertheless, it is important that we have these hearings so that we can separate some of the fact and some of the fiction so that seniors are better assured, frankly, that they are going to have a catastrophic program that is better than they may now think.

I thank you again, Mr. Chairman, for this hearing.

The CHAIRMAN. Thank you.

Senator Durenberger.

OPENING STATEMENT OF HON. DAVID DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, I thank you for giving us the opportunity to review today the basis for the Medicare Catastrophic Coverage Act financing decisions that we made just about a year ago, I think, when we came out of conference. I had hoped that the result of this rather long hearing is that we are better informed, but also that we resist the temptation to tinker with an historic piece of work because of some imprecision in estimating its costs.

As the Chair said, the support for this bill is going to continue to grow in the future. And to use Bob Packwood's analogy, I might say that perhaps out of the context of MCCA that what we are doing today is making a mountain out of a mountain. Because, Mr. Chairman, the problem that we address today is not so much our disagreement over the revenue effect of this bill, but it is impossible to reconcile the disagreements over how much use is going to be made of this new system—of catastrophic, of long-term care, a variety of benefits including this very large and unpredictable drug benefit.

But then I would say, Mr. Chairman and my colleagues, that the number one health problem that we face in America today is the fact that we cannot estimate the cost of getting sick in America. And all we see is our health insurance premiums going up 20, 30 percent a year; the doctor's bills are going up; Medicare expenditures are going up. Everything is going up and so is the number of people who cannot afford to buy health insurance; the number of people who cannot find doctors and get into hospitals; the number of elderly who have to buy these unnecessarily large Medigap policies just out of fear.

So when I say the importance of this hearing is to use Bob's analogy—a mountain out of a mountain—I think the problem we have to keep our eye on here today is the fact that we cannot estimate costs in this almost out-of-control health care system of ours. If the public cannot estimate them, I am not sure we're the best mountain climbers in the world either because our record is not necessarily one that says we have done a really good job of it.

But if it is going to be done anywhere, it is going to be done in this Committee, and it is going to be done with your leadership, Mr. Chairman, and Bob's leadership. It is that reason that I think it is very, very helpful that you have these hearings today.

The CHAIRMAN. Senator Boren.

OPENING STATEMENT OF HON. DAVID L. BOREN, A U.S. SENATOR FROM OKLAHOMA

Senator BOREN. Mr. Chairman, I want to join the others in thanking you for calling these hearings. You have been the leader on this issue all the way through. You sheparded us through over 2 years of very detailed work on this problem and because of your efforts today we do have in place what I think all of us feel is an important protection for over 32 million Americans under Medicare: that is protection against the devasting effects and high costs of catastrophic illness that wipe out the life savings of many, many people.

These are important protections that are now in place. But I think it is right for us now to focus on the manner of financing it. The undue share of the burden for balancing the budget should not be put on the backs of the senior citizens. We should not misuse the amount of premium collected to build up balances in the trust fund as a hidden way of shifting the tax burden on the senior citizens for trying to reduce the budget deficits that all of us should share in an equal fashion in trying to reduce.

So I think these hearings are important. I think we should focus on the financing mechanism. If we can find a way to reduce the burden of the premiums we should do so and I simply want to commend you for your leadership in calling these hearings to focus on the entire problem and will ask consent that the balance of my statement be placed in the record.

The CHAIRMAN. Without objection.

[The prepared statement of Senator Boren appears in the appendix.]

The CHAIRMAN. Senator Heinz.

OPENING STATEMENT OF HON. JOHN HEINZ, A U.S. SENATOR FROM PENNSYLVANIA

Senator HEINZ. Mr. Chairman, I think there are a lot of important issues that arrive in our mailbox regarding the catastrophic legislation; whether or not the distribution of the financing is equitable, whether the participation in the program should have been made truly voluntary, whether the people who are double covered by virtue of their participation in an employer-provided plan are being treated fairly. I think these are all legitimate issues.

But it seems to me that we have some problems in estimating the cost of this program and the revenues that are needed. Both Senator Mitchell, who was Chairman of the Health Subcommittee at the time, and I, were deeply involved in the process of estimating the costs of this program when it was enacted. I was pleased to work closely with him on this Amendment. But the problem we encountered was that there were widely divergent costs estimates.

The difference between the estimate of the Congressional Budget Office and the Office of Management and Budget was at times in the neighborhood of 300 or 400 percent. It does illustrate the point that Dave Durenberger and others have made—that we do not know how to estimate the cost of such a program. Clearly, if we want to avoid cutting benefits back, we have to have the money to pay for them.

My final point really is that Pat Moynihan is absolutely right when he says that the way to solve this problem is to stop using surpluses from any of the Social Security trust fund accounts, including this one, as if they are deficit reduction solutions. What we ought to do, it seems to me, is to take this program entirely out of the Federal budget at the earliest possible moment. I would like to do that with all of the Social Security trust funds. I would like to do it tomorrow. But I realize that we cannot do that tomorrow because we are already hooked on $50 billion or $60 billion of deficit reduction surpluses from the trust funds.

But this—the catastrophic program—could take off, get it out of the argument of politics and balancing the budget on the backs of the elderly, and try and run it as a good program, free from the politics of whether or not someone is accusing us of doing something unseemly with the revenues that are collected.

So that would be my suggestion, Mr. Chairman. I hope we can move in that direction.

The CHAIRMAN. Senator Chafee.

OPENING STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM RHODE ISLAND

Senator CHAFEE. Thank you, Mr. Chairman. Again, I want to join in thanking you for holding these hearings.

I think it is important to remember that the catastrophic premium is coming in exactly according to the estimates. The supplemental catastrophic premium has not been paid yet, except through withholding or on estimating tax payments.

But what we are debating here is a difference between estimates that were made last year, or the year before, and estimates that are being made this year. Furthermore, we do not have any statistics on actual expenditures. We are only dealing with estimates there too. The point I am making is that we are still arguing over estimates before this Committee as we consider what action we should take.

Secondly, maybe there are better options to be presented under this program. As perhaps most of the members recall, when this legislation passed the Senate, the beneficiaries retained their ability to opt out under Part B. We went to conference with the House and the House refused to give us that option. In other words, in order to get a bill, we could not go forward with the ability to opt out under Part B. Maybe we should reconsider that. We can look at that again.

So I think this is going to be a worthwhile hearing, Mr. Chairman, and I look forward to the testimony.

Thank you.

[The prepared statement of Senator Chafee appears in the appendix.]

The CHAIRMAN. Senator Riegle.

OPENING STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM MICHIGAN

Senator RIEGLE. Thank you, Mr. Chairman. I think this is one of the very important hearings that we will have this year and I thank you for convening the hearing.

I support the position, Mr. Chairman, that I think you have taken—namely that if our estimating work were to indicate that there is a build up of a surplus in this fund and we can verify that, I would like to see that surplus go back to the seniors themselves. I do not think we ought to be taking and raising more money than may be needed here and in effect use it in an accounting sense to reduce the reported size of the Federal budget deficit, which is a separate matter.

And clearly, that is happening today. But these estimates do move around. I am sensitive to that argument and to what the true cost patterns would indicate to us.

Also, we are going to hear from a number of witnesses today about whether or not we ought to consider, in addition to the excess financing question, the basic question as to whether or not we were sound in deciding on this as a method of raising the money to pay for this very important catastrophic health insurance coverage.

I think we ought to weigh carefully all ideas in this area. If someone can come up with a sounder and better way over time to finance this kind of insurance coverage and even a broader package of coverage of the kind that the late Senator Pepper talked about, dealing with nursing home care and so forth, then I think we have to be prepared to consider them.

But I will look forward with great interest to the comments of our witnesses today, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Now I will state once again for those members who have come in since that point, Dr. Sullivan has a commitment—a speech on the West Coast—this afternoon and we have agreed to take him first this morning. We are most appreciative of having you. We are looking forward to your testimony.

Dr. Sullivan.

STATEMENT OF HON. LOUIS W. SULLIVAN, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. SULLIVAN. Thank you, Mr. Chairman.

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss with you financing issues relating to catastrophic health insurance under Medicare.

The administration's report, recently transmitted to Congress, entitled "Expenses Incurred by Medicare Beneficiaries for Prescription Drugs" confirms our initial estimates of the drug benefit and indicates that the financing of the catastrophic drug insurance trust fund is not appropriate. The drug trust fund is seriously underfunded. The basic catastrophic benefits are appropriately funded.

Catastrophic health insurance represents the most comprehensive expansion of Medicare since the program's inception in 1965. The concept of catastrophic health insurance was forwarded by the former administration and embraced by Congress over 2 years ago. Following more than a year of congressional debate and months of dialogue between Congress, the administration and beneficiaries' groups, the Medicare Catastrophic Cover Act of 1988 became law last July.

Catastrophic health insurance may protect Medicare beneficiaries from the financial ruin an unusually long, or particularly expensive acute illness cause. The need to protect Medicare beneficiaries from such a risk has become increasingly clear in recent years as the cost of health care has risen dramatically, and with it the burden of beneficiary cost sharing for the most serious illnesses.

Since I think most of us are familiar with the details of the catastrophic health insurance benefits, let me outline them for the record.

The catastrophic benefits were incorporated into the catastrophic health insurance legislation for several reasons.

First, millions of beneficiaries lack this coverage. While most beneficiaries purchase private insurance to supplement Medicare coverage, these plans vary in the extent to which they cover acute catastrophic expenses. Some beneficiaries lack catastrophic coverage entirely, some intentionally, others for lack of resources. Thus, some beneficiaries are not adequately covered for the risk of incurring acute catastrophic expenses.

In addition, as you well know, several groups representing Medicare beneficiaries encouraged the development of the legislation and were actively involved in its evolution.

Finally, because the benefits are financed by beneficiaries themselves, the underlying principle of the financing mechanism for the benefits is fiscally prudent. As Congress greatly expanded the relatively modest benefit proposal initially forwarded by the Reagan administration, it became clear early on in the congressional debate that flat premium financing—that is premiums paid in equal amounts by all beneficiaries would have been excessive for a great many beneficiaries.

The financing mechanism which subsequently emerged to support the benefits included a flat Part B premium to be paid by all

Medicare beneficiaries and a supplemental premium related to Federal income tax liability. Revenues from the flat Part B premium finance about one-third of the catastrophic benefits while revenues from the supplemental premium finance roughly two-thirds of the benefits.

This financing mechanism represents a fundamental change in the way Medicare benefits are financed in at least two respects. Perhaps the most significant aspect of the financing mechanism is that for the first time new Medicare benefits are to be financed solely through premiums paid by beneficiaries themselves. The development of the legislation was contingent upon sustaining this feature.

Both Congress and the administration agreed that general revenues would not be used for the further expansion of Medicare benefits. Second, beneficiaries with higher incomes are required to pay supplemental premiums in order to preserve the benefits package. It is reasonable to expect all individuals who could benefit from the new law to contribute to its cost.

The new financing mechanism had the potential to entirely derail the legislation and indeed many opposed it in principle. However, when the choice became one of adopting the new benefits financed by both flat and supplemental premiums, or not securing the benefits at all, everyone, Congress, the Reagan administration, and beneficiary groups supported, on balance, the legislation.

I would point out, however, that even as President Reagan signed the bill into law he cautioned policy makers that the volatile costs of the outpatient prescription drug benefit could far exceed what was projected.

Some beneficiaries have taken issue with the financing mechanism designed to pay for the new benefits. I know that many in Congress have heard from those beneficiaries who believe that the supplemental premium is unfair, both in principle and in the amounts to be paid.

We at the Department hear from these beneficiaries as well. I believe we would be recreant in our responsibility to them not to carefully examine their concerns. At this time, however, we remain committed to the continuing implementation of catastrophic health insurance under Medicare.

As I understand it, Mr. Chairman, your proposal for reducing the supplemental premium by an average of 16 percent is premised on revised Congressional Budget Office and Joint Committee on Taxation estimates of premium revenues. These reestimates reveal a larger contingency margin than estimated when the legislation was enacted. I note that the contingency margin specified in the legislation may not provide adequate protection. If they were calculated using an acceptable actuarial methods, they would translate into a 5-percent margin.

You propose to use this so-called surplus to reduce supplemental premium amounts. Allow me to outline several reasons why we believe your approach is not in the best interests of beneficiaries or of the Medicare program.

The CHAIRMAN. Let me correct that right now. I have not made such a proposal. I have stated that as one of the options to be considered. And that this hearing is to better understand the availability of such an option.

Dr. SULLIVAN. I accept that correction, Mr. Chairman. Thank you.

The administration has also re-estimated the costs of catastrophic health insurance. While it is true that premium revenues are somewhat higher and benefit outlays are somewhat lower than projected when the legislation was enacted, we remain concerned that the outpatient prescription drug program is in a seriously compromised financial position. We cannot recommend a reduction in premium revenue at this time knowing that the drug benefit faces financial difficulty in the near future.

The new estimates of the Medicare outpatient prescription drug program continue to show that the program is considerably underfunded. Over the first 4 years of the program, encompassing 1990 through 1993, benefit payments are expected to exceed premiums received by nearly $800 million. With administrative costs included, the shortfall rises to almost $2.8 billion. By the end of 1992, we project that there will be insufficient cash on hand in the catastrophic drug insurance trust fund to pay claims and some benefit payments will have to be deferred until additional premiums come in.

I understand that HCFA actuaries and CBO have never been in agreement with regard to the cost of the outpatient prescription drug benefit. Because of continuing misgivings, some have expressed about these differences, I asked the actuarial firm of Towers, Perron to review the estimates—specifically, the actuarial projections in the recent report to Congress. I have been advised that, indeed, the findings are appropriate and that the independent review strongly supports the conclusion of the report.

Let me now describe some of the assumptions the Department used in calculating its most recent estimates. The Department estimates that Medicare beneficiaries who purchased at least one outpatient prescription in 1988 purchased an average of 21.5 prescriptions in that year. We estimate that by 1993 outpatient prescription drug users will purchase an average of 23.3 outpatient prescriptions. We also estimate that the average cost per outpatient prescription drug in 1988 was $18.21 and will increase to $24.26 by 1993.

Perhaps the most difficult element of the program's cost to estimate is that of induced demand. It is commonly acknowledged in the insurance industry that the very act of coverage tends to increase demand for the covered service. This insurance effect is called "induced demand." HCFA actuaries assume an insurance effect in 1991 that would increase aggregate consumption of drugs by the Medicare population by about 10 percent. In 1992, as the coinsurance rate for outpatient prescription drugs falls, aggregate consumption is projected to be about 12 percent higher than it would have been in the absence of the program. In 1993, an increase in the deductible and a decrease in the coinsurance rate produce effects that partially offset each other, resulting in consumption that is projected to be about 11 percent greater than what would have been the case in the absence of the program.

Estimating future outlays is always a risky business and in this case, the dearth of good information upon which to base estimates makes it even harder. We need to be very cautious in our financing of this new benefit. We cannot afford to contribute to the insolvency of the drug trust fund.

If history can provide any insight into the inherent difficulty of estimating the costs of new benefits, we need only look at the evolution of other benefit programs to learn valuable lessons.

When the original Medicare legislation was enacted, Part A benefit outlays were projected to be $5.7 billion for the 4-year period encompassing 1967 through 1970. Actual Part A benefit outlays for this period were $15.7 billion. We anticipate Fiscal Year 1990 Part A outlays now of $63.1 billion.

Secondly, when the End Stage Renal Disease Program was implemented, it was expected to cost $170 million for a 4-year period, encompassing 1974 through 1977. The program's actual costs in those years were $878 million. And in Fiscal Year 1990 we project comparable end stage renal disease expenditures of $1.15 billion.

While there are many reasons, including benefit expansions, why these programs grew faster than predicted, I think we would be wise to keep them in mind and proceed with seasoned caution rather than youthful optimism at this point. In drafting the catastrophic coverage legislation, Congress provided for the possibility that the program could be initially overfunded.

To address this possibility, the current financing structure contains a mechanism to hold the line on premium increases starting in 1994 if too much revenue is collected during the early years of the program. However, were Congress to cut the premium rates today, there is no comparable automatic mechanism to increase premiums in time to maintain the solvency of the drug trust fund.

In addition, if premiums were reduced and the actuary's estimates confirmed by actual expenditures, Congress could be forced to introduce general revenues into the financial mix. This may at first be presented as a temporary fix but once done it would be very difficult politically to reverse. A first principle with respect to the legislation was that no general revenues should be used. And Congress, throughout discussions on this legislation, was in agreement on this point.

In light of these very sobering points, it would be extremely injudicious to reduce supplemental premium revenues before all of the catastrophic benefits are fully implemented.

I should point out at this time that the implementation schedule for the drug benefit is extremely tight. Implementation on January 1, 1991 will require the timely execution of a number of critical tasks both inside and outside the Department. Perhaps the largest task we face is the procurement of the congressionally mandated electronic bill processing system. The full cooperation of all parties will be required in order to accomplish what is, by any measure, a very complex procurement.

There is virtually no tolerance in this schedule. Any delay in this process will make implementation within the legislatively required time frame extremely difficult to achieve.

In concluding my remarks, I would point out that the Medicare program remains a Federally subsidized health insurance program.

The bulk of Part A benefits are paid for by current workers through a payroll tax, and 75 percent of Part B revenues are financed through general revenues. Clearly, although Medicare beneficiaries have been asked to contribute to financing the new benefits, they are still paying far less than the market value of their Medicare benefits.

Let me conclude my statement by assuring you, Mr. Chairman, that we want to encourage discussion of issues affecting the Medicare program. We will continue to listen to beneficiaries and taxpayers; we will make changes where we can; hopefully make decisions characterized by integrity and prudence; and above all, do what is in the best interests of beneficiaries. Indeed, I believe that more harm can be done by being overly optimistic about the financing of these new benefits than by being prudently cautious. The continuing implementation of catastrophic health insurance under Medicare is the most appropriate course of action.

Thank you very much, Mr. Chairman, for the opportunity to present this statement. I would be pleased to respond to questions.

The CHAIRMAN. Thank you very much, Mr. Secretary. I think that is a good statement.

As I stated earlier, when it comes to a question of funding benefits I am pretty prudent on that. I have been down the road and I have seen the mistakes of the past and they were recounted time and time again in our deliberations. I was particular concerned about the prescription drug benefit and that it be phased in, and that there be mid-course corrections if that is necessary on the part of the administration, and to give them that additional flexibility.

I agreed very much with the President as to the excess amount of reserves that we should have in regard to that. That we should have a very substantial cushion. What we are now seeing is a cushion that looks like it will be double what we had requested in that regard. So I understand the concern there and I share it. But there is a point in which it is just not a matter of prudence anymore, it is a use of resources and an understanding that we are talking about a premium that is a heavy burden for those that are paying it and to see if we are perhaps going beyond what is necessary.

As we are looking at those numbers, one of the questions that I was concerned about was a missing vital source of information. That was the annual report of the Board of Trustees of the Medicare hospital insurance Part A trust fund.

Now that was due on April 1, can you tell me why that report has been delayed and when we can expect it?

Dr. SULLIVAN. I would have to get that answer back to you, Mr. Chairman, as to when it would be forthcoming.

The CHAIRMAN. Well, when we are talking about deliberations like this, that is an important one, and I do not know why it has been omitted. Why we have not utilized it. Why we have not had available to us that kind of information. It is important that we get it.

[The answer follows:]

Senator BENTSEN. Why has the annual Medicare health insurance (HI) report of the Board of Trustees been delayed and when can we expect it?

Dr. SULLIVAN. The Annual Report for the Supplementary Medical Insurance program was submitted to the Congress on April 24, 1989. The Annual Report of the

Board of Trustees for the Hospital Insurance (HI) program has been delayed because the financial status of the HI program is now intertwined with the financing of the new catastrophic benefits. The Trustees are required to report on the income to the HI program as well as the income to the HI Catastrophic Coverage Reserve Fund. To assess the adequacy of the catastrophic fund, it is necessary to include Treasury Department revenue projections from the income tax-based supplemental premium.

The Report of the Board of Trustees for HI and the Catastrophic overage Reserve Fund will be finalized and submitted to the Congress approximately 2 to 3 months after the information necessary to complete the 75 year projections of the income-related revenue becomes available from the Treasury Department.

The CHAIRMAN. Now, Mr. Secretary, the administration has now revised downward its estimate on the cost of the prescription drug program by about 10 percent. Can you review for us the factors that led to that kind of an estimate?

Dr. SULLIVAN. The estimates that we have made, Mr. Chairman, we have done with the help of consulting actuaries as we indicated to you. They have indicated their concurrence with our estimates. I have to again emphasize that we are dealing with estimates. And because of the many examples, where in spite of the best minds being put to this test, we have often times come up with greater expenditures than projected, we have tried to use the best figures available to us and exercise the greatest caution. We believe that our position is the most prudent one at this time.

The CHAIRMAN. But you cannot tell me what the factors were that led to a lowering of those cost estimates? You do not know what they are?

Dr. SULLIVAN. I can get a response back to you, Mr. Chairman.

The CHAIRMAN. I want the specifics on that for the record.

[The response follows:]

Senator BENTSEN. The administration has revised downward its estimate on the cost of the prescription drug program by about 10 percent. Can you review for us the factors that led to the lowering of those cost estimates?

Dr. SULLIVAN. First, the most significant factor was a reduction in projections of prescription drug price inflation. When catastrophic legislation was being debated, we were assuming that prices would rise an average of $25.40 per prescription by 1993. By the time we prepared the Department's report to Congress some 18 months later, the projections had been reduced by 9 percent to $23.20 per prescription.

Second, the projected number of Medicare enrollees has been revised downward since the debate over enactment. At that time, we estimated that there would be 34.960 million people enrolled in Part B in 1993. In the report, we assumed a figure of 34.586—1.1 percent lower than the earlier estimate.

Finally, there has been a revision of the projected number of prescriptions per enrollee. We had assumed that in 1993, 78 percent of aged, noninstitutionalized enrollees would use at least one prescription. Based on data from the National Medical Expenditure Survey, we increased that rate to 85 percent. Offsetting this, however, the user rate for the disabled population was reduced from 100 percent to 82 percent, based on the same data. The number of prescriptions per aged user in 1993 was reduced from 24.8 to 22.1, while prescriptions for the disabled were increased from 30.3 to 31.3.

The CHAIRMAN. Now, as we were negotiating with the administration on prescription drug benefit, we agreed in the face of considerable uncertainty over the costs of that benefit that the drug insurance trust fund would be financed so as to achieve significant contingency margins—as you were stating, particularly in the programs early years, that we wanted that.

It was our intent that initially those would be as high as 75 percent or 175 percent of the total reserves. Now I know that CBO differs with your analysts over projected spending from the trust fund, but what I would like to ask, if the contingency margin were set, taking into account the administration's estimate of drug spending, would you consider a 75 percent margin sufficient? If we took into account their estimates. And what levels of flat and supplemental premium would be required to achieve a 75 percent reserve if your estimates were used?

Dr. SULLIVAN. Let me consult with one of my colleagues, Mr. Chairman.

The CHAIRMAN. All right.

[Pause.]

Dr. SULLIVAN. Mr. Chairman, I am advised that because it does represent a hypothetical situation it would really take extensive analysis to give a precise response to your question.

The CHAIRMAN. Well, I would say, Mr. Secretary, up to now I have batted just about zero in so far as answers from you as to the specifics. So I will want that for the record. And I have a whole list of questions that I will want answered for the record that I will submit to you. I would go through it on the second round, but I am trying to let you make your plane.

[The questions and information appear in the appendix.]

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Let us see if we cannot continue this batting practice, Mr. Secretary. It is just a pattern we have here sometimes.

Do I take, sir, from your comments on page 7 that were Senator Bentsen, the Chairman, to introduce legislation along the lines of a possibility he has raised, which is to say to cut the premiums back to where we seem to be actuarily imbalance, would you, sir, recommend that the President veto such a bill?

Dr. SULLIVAN. At this point, Senator Moynihan, we believe that we have exercised the most prudent position concerning the situation. We are concerned that the drug benefit is underfunded and we are concerned about any action that would impair the integrity of the program. If there were actions that really violated that integrity, I think I would have no alternative but then to recommend that the President indeed not concur.

Senator MOYNIHAN. That is a fair comment and I think some of us may wish you could see otherwise, but it is a fair statement and I thank you, Doctor.

The CHAIRMAN. Let me assure you, Mr. Secretary, if it was imprudent I would not recommend it. [Laughter.]

Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman.

Mr. Secretary, back to the issue of induced demand—and I think the issue of induced demand in the prescription drug program is one of the, let us say, cost escalators that your people are determining are going to rapidly increase the cost of the prescription drug program.

I wrote you a letter some weeks ago in which I raised this question. I asked you why you had not—your people or you—taken into consideration the National Center for Health Services Research, who studied in depth this issue. And I will read you their conclusion, if I might, and I quote, The National Center for Health Services Research stated, "There are no significant differences in prescription drug use or expenditures between insured persons with prescription drug coverage and those without prescription drug coverage."

Now you failed to mention this in your report to Congress. It is my inference from this that you are basically hiding this information produced by a highly reputable research arm and that you are going forward and not taking into account this finding; and therefore, you are escalating the prescription drug cost projections. They say that an insured Medicare population would produce little or no induced demand.

Could you comment on this?

Dr. SULLIVAN. Yes, Senator Pryor, thank you. We do not concur in that position, Mr. Pryor. Our actuaries in HCFA, as well as our consultants from Perron and Tower, as I mentioned, believe that there is no question that there will be an induced demand. And the magnitude of that induced demand that our actuaries have projected was felt to be appropriate and is consistent with the actual experience of many other programs, such as the UAW program and the drug program of the Association of American Retired Persons. Our position on induced demand is based upon the experience in similar programs being implemented.

The actuarial expertise in our Department is in HCFA and the study by the National Center for Health Services Research did not take into account those actuarial perspectives.

Senator PRYOR. And so you did not take into consideration the findings of your own research arm—NCHSR?

Dr. SULLIVAN. We certainly did take them into consideration, but they did not include an estimate for induced demand. Our staff in that agency, indeed, in looking at their projections versus the HCFA projections have agreed that the discrepancy between their reports, when one takes induced demand into account, is really not very significant.

Senator PRYOR. Okay. I may want to come back to this line of questioning later if we have time. I know we have many witnesses, Mr. Chairman, but one additional question which is the first cousin of what we are talking about, I guess you would say, and that goes to the drug utilization review.

Now the General Accounting Office stated to me—now I will quote from page 4 their conclusion—"In addition the experts we have spoken to are unanimous that a DUR system could be incorporated into the drug claim bill processing computer system." In other words, it could be presently patched to the system. Now it appears that you and your people are going out to reinvent the wheel, make all kinds of studies of the type of system we need. This system, of course, does not get only to the basic issue of safety for the prescription drug user, it also certainly relates to the economics of this system and whether or not people are going to be buying more drugs than they actually need.

The GAO says that we have networks that are workable now and that can be patched in. Do you disagree with the General Accounting Office?

Dr. SULLIVAN. Senator Pryor, I have not seen that report. But we will certainly be happy to review it and to examine it. We want to do everything we can in the Department to indeed implement this program and have it available to our citizens. We are concerned, as I mentioned in the testimony, about the tight time schedule of implementation that we have. And indeed, if we can find ways as suggested in this report to utilize existing technology, we will certainly be more than happy to do that.

Our basic premise, and our concern, is to get the program up and running. And if, indeed, our people agree that this exists, we will be more than happy to utilize it.

Senator PRYOR. I hope you will look at this report, Dr. Sullivan.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, having lived as everybody did through the experience of groping our way through the drug benefit, it is very difficult to even think of the right questions to ask at this stage on that particular point. But the insinuation at least that was in my dear colleague's question, that the administration is trying to cover up anything on the drug side, I take it as an inappropriate insinuation. Is that not correct?

Dr. SULLIVAN. That is correct, Senator Durenberger. Certainly not I, nor my staff, to my knowledge, have been a part of any discussion that would suggest any use of these reserve funds other than for the catastrophic program itself. We state that in our testimony and we are certainly committed to that.

We are concerned about preserving the integrity of the program itself. This is the reason for our position.

Senator DURENBERGER. Okay. And the problem that we all had is all of the people who are in the drug business were telling us we had a bigger problem than we thought we had when we were drafting this. They told us about the fact that from 1980 to 1986 prescription drug costs went up 11.2 percent and the per capita use of prescription drugs was going up 14.2 percent. So DHHS added another 10 percent in the estimates to cover it, even though we did not know how it was going to come out.

Instead we said to DHHS that we need the information from the current drug use study, the Current Population Survey, we need you to do a good job on induced demand or the so-called insurance effect and by that getting into consideration of the changing role of medigap, and then to try to do the impossible which is to judge the impact of the presence of insurance on the cost of a prescription—how much more will doctors prescribe that they might not have prescribed before; what will the impact be on the pharmacies; what will the impact be on marketing of drugs?

There just is not a whole lot of precise information out there and I take it that is why you were asked to take on the burden that probably is not very easy for you to deliver on in a short period of time. Is that generally correct?

Dr. SULLIVAN. That is correct, Senator Durenberger. We feel that there have been a number of examples, as I mentioned, of induced demand causing greater utilization than was projected. Because of this dispute, or this concern, we felt that it would be important to get an independent opinion. We sought the best advice that we could get and, indeed, were supported in that position.

Senator DURENBERGER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Heinz.

Senator HEINZ. Dr. Sullivan, one of the elements of the prescription drug benefit which you brought up as the reason for caution in any action by the Congress, one of the characteristics of it that we have all mentioned, is that it is hard to estimate. It is very controversial.

It would be very helpful to us, not only to know as was asked by Senator Bentsen earlier what the differences were between this current estimate and the previous estimate which is apparently some 10 percent higher, but also if you can answer the following questions. There were a number of provisions in the catastrophic drug benefit included specifically to limit cost increases, particularly the kinds that you have referred to. One of these is the payment limits for multiple source and nonmultiple course drugs. A second was limits on prescription supplies. A third was a fairly high deductible with which you are familiar. And fourthly, a drug utilization review program, which Senator Pryor mentioned in his opening remarks. And in addition, there were some other elements—the electronics claim system, the oversight by the congressional Commission that we establish penalties, ample reports on cost and utilization.

My question is, particularly in view of the first four things I mentioned, why are we certain that the cost that has been provided to you by your actuaries is, indeed, going to be as high as you think? Did you take into account, for example, the drug utilization review system and what effect did that have on the cost estimates?

[Pause.]

Dr. SULLIVAN. Thank you, Senator Heinz. We have, indeed, taken into account the drug utilization review in estimates. Part of the response to your question is the fact that, of course, we have more and more of our citizens turning 65 who have coverage for drug benefits. We know that, again from experience, the availability of such coverage is usually associated with the higher degree of utilization.

We will provide you with a complete response to the various points you have made and for the record as well.

[The information appears in the appendix.]

Senator HEINZ. I know that you have an interest in this program—that is to say the drug utilization review program—and I know you have stressed in your statement how hard it is just for you to get an appropriate electronic claim in place by the 1st of January, 1991. How high a priority are you giving the establishment and implementation of a drug utilization review program?

Dr. SULLIVAN. It has the highest priority, Senator Heinz. We have had a number of meetings of colleagues within the Department, not only in HCFA, but in our other components of the Department and we are, indeed, working as hard as we can to implement this on schedule. The point we were making earlier is that this is a tight schedule but is one that if, indeed, there are not unanticipated delays we will be able to meet. But our experience in other programs has indicated that frequently there are intervening factors that will come into place.

So we are simply drawing the attention of the Congress to that. But we are fully committed to implementing this on schedule to the best of our possible ability.

Senator HEINZ. Senator Wilson of California, and I, introduced a follow up drug utilization review bill. Are you familiar with that legislation?

Dr. SULLIVAN. No, I have not reviewed that.

Senator HEINZ. Let us be sure and send you a description of, the legislation, because we believe that this legislation would be helpful to HCFA and to the beneficiaries. We would urge you to take a look at it, but if you possibly can, strongly support.

Dr. SULLIVAN. We'll be happy to review it.

Senator HEINZ. Thank you.

The CHAIRMAN. Thank you.

I had promised the Secretary he could leave at a quarter till 11:00 so he could catch his plane. So we will take just one more question and that's Senator Riegle.

Senator RIEGLE. Thank you, Mr. Chairman; I'll be very brief.

First of all, Dr. Sullivan, I want to compliment you on your presentation today and the good start that you have made in your assignment. It is a difficult one and I am very pleased that you have it and I just want to acknowledge what I think has been a very fine start by you in this assignment.

Let me go specifically to the issue here at hand. And that is, if we should find that we are developing a surplus —if we determine, for example, that we are building up a surplus, even if it is for the drug benefit that phases in, that is larger than is needed would it be your view that any overage beyond the amount that is needed just for an actuarially sound margin should develop, should that go back to the seniors as a matter of principle? If we find that we are accumulating more than we should, what should we do with that?

Dr. SULLIVAN. Yes. Our position, Senator Riegle, is that the premiums obviously should be and are intended to be used only for the catastrophic program itself. There is a mechanism in the legislation that would allow for automatic adjustments to be made if, indeed, we find that as we gained experience the premium collections are in excess of what is actuarily sound, that is needed for the program.

Senator RIEGLE. Well, is that another way of saying that you then would accept the premise and the approach that would say, that if we are building an unnecessarily large surplus that you, in fact, would support some manner of a rebate system to pay that overage back? Is that right?

Dr. SULLIVAN. An adjustment that may result, for example, in lowering of the subsequent premium. I think that in principle, yes, we are.

Senator RIEGLE. Now let me ask you one other question. I am very leery of whether or not OMB would be putting pressure, not just on you and your Department, on all Departments to take and to generate every manner of trust fund surplus to use it to understate the true size of the Federal budget deficit. I mean, I think the Gramm-Rudman discipline is an inherently dishonest one. I think the accounting is dishonest on its face. But we are using the Social

Security trust fund surpluses now as accounting offset to make the deficit lower.

What I am asking you is, have you had any discussions with OMB where they make it clear that they want to maintain these surpluses, whether it is in catastrophic premiums or what have you, for the obvious purpose of reducing the reported size of the budget deficit? Are you hearing from them on that issue? Have they said anything about that to you?

Dr. SULLIVAN. No. There have been no discussions by me and any OMB official concerning use of those trust funds for deficit reduction purposes.

Also I point out that in President Bush's letter to Mr. Rostenkowski, he said that the use of these monies in the trust fund would be only for the purposes of the catastrophic bill itself and for no other purpose. So I think we are very clear on that.

Senator RIEGLE. I am not going to hold you long. You have a plane to catch. I am concerned about that. I do not doubt the honesty of your answer. But I strongly suspect, because I see it in all these other cases, the building up and the use of these trust fund surpluses to understate the true size of the Federal budget deficit and I am concerned that it may well happen here.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Secretary, you have done a good job and it has been helpful. In fairness to you, some of the questions that I asked you are somewhat technical and I will look forward to getting the answers from you and the additional questions that will be submitted by other members of the Committee. We are most appreciative of your testimony. It has been very helpful.

Dr. SULLIVAN. Thank you, Mr. Chairman. I very much appreciate your courtesy in allowing me to make my commitment on the West Coast.

The CHAIRMAN. Thank you.

Dr. SULLIVAN. Thank you.

[The questions appear in the appendix.]

The CHAIRMAN. Now we will call on the members that have requested time before the Committee. As I look to determine the order in which we hear them, I have asked the staff how they listed them here and they told me they made a very courageous decision. They chose in the order of the applications received.

So, Senator Wallop, we will be pleased to have you lead off.

STATEMENT OF HON. MALCOLM WALLOP, A U.S. SENATOR FROM WYOMING

Senator WALLOP. Thank you, Mr. Chairman. Perhaps that comes of institutional memory. If you want to testify, you get it in early, using the early-bird rule.

Might I say that with all the appearances that I have been making before your Committee lately, I feel like an ex officio member of sorts.

The CHAIRMAN. I must say, I do not want to limit any of you, but I have to ask you to hold it to 5 minutes and we will take the whole statement for the record.

Senator WALLOP. I will.

The **Chairman**. Thank you.

Senator **Wallop**. If recent calculations by the Health Care Financing Administration are accurate, the physicians in my State of Wyoming will, if the rural health care proposals come about, finally receive adequate reimbursement for services if we legislate the RB-RVS approach. Adequate reimbursement is a major problem in my largely rural State with Medicare reimbursements trailing those in surroundings States. Wyoming has encountered terrible troubles in attracting new physicians.

A more equitable reform will improve physician recruitment for Wyoming. It will also mean that we will be able to provide new benefits such as those passed under the Catastrophic Health bill that Congress passed last year.

Today, appropriately, your attention is focused directly on the benefits provided by the Catastrophic Care bill—the first major expansion of Medicare since 1965. Over the past few months, every Senator has undoubtedly received letters from seniors in his State expressing displeasure with the new program. Interestingly, I conducted a large survey of Wyoming senior citizens at the time we were considering this legislation which showed a vast majority of seniors believed that catastrophic coverage was a necessary health benefit.

So why the displeasure from so many seniors? It seems that the supplemental premium, which institutes a means test based on income, is a rod for the lightning of this discontent and it is mandatory. Many seniors say they do not need the new benefits and do not want to pay for them. Others simply say they cannot afford another fee and should not be forced to pay one.

In my opinion, controversy surrounds the new benefit bill mainly because we were forced to accept language from the House of Representatives which required mandatory participation—either that or we would have forfeited the opportunity to provide a catastrophic benefits bill.

The original Senate catastrophic bill was a voluntary provision tied to Part B. During the floor debate on this bill, I offered an amendment which would have made the catastrophic benefit a separate voluntary benefit. Although my amendment was defeated, I am not as yet convinced that we have lost the war. I reintroduced it as a new bill, S. 608 and as the uproar over the supplemental premium costs continue to rise, I continue to gather support for this proposal.

Were we to make the program voluntary as I proposed, obviously there would be some seniors who would drop out of the program. But the Part B voluntary participation rate is 95 percent of all eligibles, and I would expect such a good showing for the catastrophic benefit. People will realize that it is an important benefit and they will seek it. I come from the perspective that voluntary inclusion rather than government coercion is always a better public policy and this philosophy should be applied to the new catastrophic benefit.

It is ironic that, under the law, those who have chosen not to participate in Part B of Medicare do not have to pay the basic premium for the catastrophic benefit, of about $4 a month. However, if they have any income tax obligation, they will be subject to paying the supplemental premium. That is a very odd method for structuring the financing of this benefit and it is not well balanced.

Despite the inadequacies of the structure, the program does promote some important principles which must be maintained. We have recognized the need for catastrophic health care coverage and we have found a way to provide it. We have established that the user should pay for the benefits through a means test. Again, I am convinced that the major problem is not the cost of the premium or the scope of the benefits, it is that the program is not voluntary. Simply reducing the supplemental premium does not resolve the problems with the program. We have fallen into this trap before of tinkering with the financing or the benefits in the Social Security program due to rosy predictions of a future overabundance in the trust fund.

I might add that our experience, Mr. Chairman, has been that the reserve build up in the beginning of a new program is always impressive. Perhaps the report on the health insurance trust fund, which we still have not received, may provide useful projections on its vitality. The last annual report before the catastrophic benefit was included predicted financial stress. I would like to know how things stand today.

In closing, it is interesting that we are now told that people do not want a new government benefit. This may be a new phase of public policy, inspired by the fact that people are being forced to both confront the costs of the benefits and to decide whether those costs are worth it. My solution is to let seniors decide whether the catastrophic benefits are worthwhile by making the program voluntary as with Part B.

Thank you for allowing me up here again, Mr. Chairman, before your Committee.

The CHAIRMAN. We are glad to have you, Senator. I have no questions.

Do any of my colleagues have questions of the Senator?

Yes.

Senator CHAFEE. Just one quick question. Does your catastrophic—are there three choices? They can get Part B as we used to know, or they can get Part B, plus catastrophic?

Senator WALLOP. That's correct.

Senator CHAFEE. I see. Okay.

Senator WALLOP. That is precisely the way we do it with Part B now. It is voluntary. Ninety-five percent (95%) have participation in it. I just would point out once again that you have this curiosity that if you elect not to be in Part B you escape the flat premium; but if you have an income tax obligation you owe the supplemental premium. It is a curious sort of backwards way of doing things which I think was inadvertent.

Senator CHAFEE. Thank you.

Senator WALLOP. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Wallop, you are excused or you can stay if you would like.

[The prepared statement of Senator Wallop appears in the appendix.]

The CHAIRMAN. Senator Nickles.

STATEMENT OF HON. DON NICKLES, A U.S. SENATOR FROM OKLAHOMA

Senator NICKLES. Mr. Chairman, thank you for the opportunity to make a few comments. I have a statement and also some charts. I would like to insert those for the record.

The CHAIRMAN. Without objection that will be done.

[The prepared statement and charts of Senator Nickles appears in the appendix.]

Senator NICKLES. Mr. Chairman, I think the catastrophic bill that passed last year went too far. It overextended. It duplicated coverage that 72 percent of the senior citizens already had. I think that was a big mistake. I would hope when the Chairman and others are looking at ways of making changes I hope they will look at this biggest change, and that is to eliminate the duplication. Seventy-two percent (72%) of senior citizens already had medigap coverage. They were not knocking on our doors asking for this coverage. And yet we mandated it on them and it is very expensive coverage.

For people that make $21,000 in 1989, this year, they will pay $520.50 for this supplemental coverage. Next year they will pay $846.30. Again, that is to provide a benefit that 72 percent of senior citizens already had. That is expensive—$846 for somebody that has taxable income of $21,000 is expensive. In my opinion, it is too expensive. We could reduce that cost significantly, very substantially, probably well over half if we eliminated the coverage for those people who already had it—those people who had coverage in the private sector—those 72 percent of senior citizens that were covered under some form of medigap policy.

Why should the Federal government come in and mandate coverage on top of that which was already provided for in the private sector? One of the real ironies and one of the real tragedies of the legislation is that most of those people still have it. They still are paying billions of dollars a year in their private medigap policies in addition to the catastrophic coverage that we are mandating for next year.

I would suggest that the hue and cry that we have heard from senior citizens today in our town meetings will be much larger next year when they pay their first 15 percent surcharge on their 1989 tax. It will be much greater the following year when they pay a 25 percent surcharge on their income tax as well.

So again, I think the solution is fairly simple—let us eliminate the duplication. Let us not duplicate what the private sector was already doing. We could save billions of dollars and not unfairly tax people for coverage that many already had. And many did not have to pay for that coverage, that was part of their fringe benefit package. Maybe they worked for a government, or maybe they worked for a company, that provided medigap coverage as part of the retirement package.

Why should be duplicate that? We are making them pay $500 or $800 in many cases for coverage that they already had that they did not even have to pay for. So I think we could save a lot of money for them; we could eliminate a lot of problems for ourselves; and I think restore a little bit of balance. Let us not mandate Federal coverage in an area that the private sector has already been doing. Let us provide the coverage for those persons who did not have it and who could not afford it.

If 72 percent—and that 72 percent figure came from the Committee's report—had some form of medigap coverage, let us try and help assist those people who did not have it and could not afford it. Twenty-some percent of senior citizens did not have the coverage. Many of those—probably the majority of those—could not afford it. So let us try and assist those people on the lower end of the economic totem pole and not mandate it on 100 percent of our senior citizens.

I thank the Chairman.

Senator ROCKEFELLER. Are there any questions?

Senator Durenberger.

Senator DURENBERGER. Well, maybe by way of a comment. I respect none of my colleagues' judgment more than I do my colleague from Oklahoma, but I must say the answer to the question is simply, because every once in awhile—and I know nobody likes to hear this—you come to a judgment that the private sector cannot deliver a product in health care or in health care protection that is affordable and meets the real needs of people.

The reality is, that what we legislated was probably the best health insurance benefit outside of—well, if you include all of the advantages of living in America, which some people question—that you are going to find any where in the world. And for $382.80 a year—$382.80 a year. For a couple, $765 per year.

Now by comparison, my parents—one of whom is 82, about to be 83; the other one is 78—will pay for that wonderful medigap insurance you are talking about, Don, on July 1st, even though we have catastrophic here. My parents are going to be asked to pay $1450 per year for coverage of a hospital deductible, $560; the Part B copays; and $500 for one of them, worth of drugs. Period. They are going to be asked to pay $1450 a year for that by AARP and Prudential.

Now, you know, these are very respected organizations. But nobody should have to pay that kind of money on top of what we are providing in Medicare for most people for $382.80 a month. And the reason is, we are able to put a huge subsidy through the Medicare system.

CBO will tell you, for example, that a person who is 65, this year in 1989, after all of the Medicare taxes they have paid in, all of the premiums that they are estimated to pay in for their Medicare insurance over the next—over their lifetime—they will get a subsidy of $2,649 per year in the existing program. Now, that is a lifetime subsidy of $34,000/$63,000.

Now, you know, I guess you could argue that if we got rid of Medicare and we undid the legislation of 1966, and somehow we went back to the private insurance market that maybe things would be cheaper. But I do not believe it. I just do not believe it. And I think the proof is in the kinds of products that are being put on the market today.

I could take you to the Federal employee health benefit plan. There is the private market at work. Blue Cross/Blue Shield is offering you an opportunity this year, or a retired Federal employee this year to buy one of these Medicare type packages, a high option Blue Cross/Blue Shield. All the individual has to pay is $183 a month—$183 a month or $2,196 a year.

Senator NICKLES. Is that for medigap?

Senator DURENBERGER. No, no. This is your package of basic health insurance.

Senator NICKLES. Well, that is a big difference. My whole argument—and we have to vote—but my whole argument is, we are just talking about medigap.

Senator DURENBERGER. Sure.

Senator NICKLES. Seventy-two percent (72%) of senior citizens had a medigap policy. Many of those still have it. They are going to pay medigap premiums on top of the duplication that we have imposed and the duplication is very expensive.

You mentioned the average costs $375 or something. But for a period with an adjusted gross income of $21,000 for next year—next year that is $847 per person. That is very expensive. So I would just hope that we would eliminate the duplication that the private sector was covering for medigap—not eliminate Medicare. I am not saying let's eliminate the Part B subsidy. I am saying, for medigap the bill that passed last year was very expensive, and in my opinion, not a very good deal for most senior citizens. Let's help those people that didn't have it and couldn't afford it. But let's not duplicate it for those majority of senior citizens that already had it.

Senator DURENBERGER. Well, Mr. Chairman, in case my colleague missed my point, the point is simply that this $120 a month in medigap in the private market that my folks are being charged is after we have provided catastrophic. They are not providing catastrophic; they are providing them coverage for a couple of little deductibles and $500 worth of drugs and charging them $120. Now we did not cause them to charge $120. They should have brought the rates down, not up. We ought to have a whole hearing just on that subject—how that private market—I do not want to argue with you about how well it works. I do not think it is their fault; it is probably a combination of things. That private market refused to take those prices down. They raised them and I told my folks to cancel their policy. Now I should legislate that they should not by medigap I suppose.

Senator NICKLES. I would hope that instead of legislating that people not buy medigap that we would eliminate the Federal duplication of medigap and I appreciate the Chair's indulgence.

Senator ROCKEFELLER. There will be a 3 minute recess.

[Whereupon, a recess was taken and the hearing resumed at 11:08 a.m.]

The CHAIRMAN. Cease conversation, the hearing will get under way again.

Congressman Fawell, we are very pleased to have you. I apologize for the interruption but we had a vote on the floor of the Senate.

Congressman Fawell. Shall I proceed?

The CHAIRMAN. Please, let us be sure that we have them quiet so you can be heard. If you will please be seated and cease conversation.

If you would proceed, sir.

STATEMENT OF HON. HARRIS W. FAWELL, A U.S. REPRESENTATIVE FROM ILLINOIS

Congressman FAWELL. Thank you, Mr. Chairman. I would like to thank you very much for opening this Committee session to people such as myself, who do have points that we would like to bring forth.

I am a sponsor of legislation in the House to repeal the Medicare Catastrophic Coverage Act and to form a Commission to study what should replace it. I am also co-chairing, with Congressman Bill Archer, the Republican Research Committee's Task Force on the catastrophic law. It is an immense topic.

I do want to stress several points. The Medicare Catastrophic Coverage Act is expansion of Medicare in the wrong direction. It is an expansion completely ignoring senior citizens' highest priority of health care concerns which is long-term custodial nursing home care. It is also financed by the worst of all ways: by a new income tax to be paid mostly by middle-income seniors.

The Act mandates that seniors who pay income taxes and who are eligible for Medicare will finance approximately two-thirds of this expansion of Medicare. They will also be subsidizing benefits for others. They will pay whether they can afford it or not. Moreover they will pay, even though most, as has been pointed out by Senator Nickles, are already covered by employerprovided or other private medigap insurance.

Had Congress asked seniors, they would have been told seniors' highest priorities for any new health care coverage are long-term custodial nursing home care needs, followed closely by in-home custodial health care. Neither of these health costs are covered by Medicare and, practically speaking, seniors cannot obtain private insurance coverage for these types of care. That is why long-term custodial nursing home care is the truly catastrophic fear of most seniors—and I might add, countless American families, all of whom are impacted.

Congress did not ask seniors what they wanted most. Now the seniors are telling us. Hundreds of thousands are writing Congress in opposition to the new law. Every member I know is getting an earful every time they return to their District. A key question is: Should Congress have asked seniors if this was the type of health care expansion they wanted? Well, I think so, especially since we are asking them to pay for it.

It is one thing for Congress to create a new program for which all taxpayers will pay. It is another to place a special tax on a special group of people and ask them to pay for it, to subsidize others, and then to mandate upon them benefits which do not meet their highest needs and their dire priorities. If they are going to pay for the new program, Mr. Chairman, it is my belief that we should have asked them these questions. We should have given them what they believe is the most dire of health care needs.

This Act is financed by innocuous sounding supplemental premium. But we all know that if it walks and talks like a duck, it is a duck. And, Mr. Chairman, the supplemental premium is a duck—that is to say it is an income tax.

In passing the 1986 Tax Reform Act, Congress promised it would not come back and increase individual income tax rates in the near future. Yet, it has now done precisely that to the elderly middle-income Americans, people who with the urging of Congress saved and lived frugally over many years so as not to be solely reliant upon Social Security in their retirement years. These are the same people that are most often faced with the challenge of living on a fixed on declining income. Many of them are also restricted, of course, by the Social Security earnings test from earning additional funds to meet higher costs of living, including higher taxes.

In addition, the income tax placed upon seniors by this Act, is a tax upon a tax guaranteeing what I would call a "double hit" against seniors in future years when Congress will ultimately increase income taxes, either by redefinitions of what is "taxable income" or changes in the tax rates. Those that must pay a surtax on the income tax will pay on any increase twice, first on the increase in tax and second on the surtax. A tax upon a tax.

I think Congress should go back to the drawing board and admit that the direction of the expansion of senior health care under the Catastrophic Care bill and the mode of financing are flawed. It is tough any time that one is asked to admit that perhaps Congress may have erred. The Act should be repealed or delayed, in my view, for at least 2 years.

A Commission should reexamine this terribly difficult question of how elderly health care services may best be expanded and how its costs may best be financed. The latter point is terribly difficult. The private sector, I think, should be considered as having a part to pay. What we are doing in this bill is elbowing out the private sector. Yet we have bills coming in that would emphasize the fact that all employers, for instance, should provide health care insurance for their employees. We seem to be at odds with what is basic policy in this nation.

In closing, Mr. Chairman, may I say that if Congress has not yet received this message from the people out there, I can only say perhaps, "We ain't seen nothing yet." When millions of seniors file their income tax returns next April there is going to be a popular revolt, the likes of which we have not seen for quite a long time.

Once again, Mr. Chairman, I do appreciate your openness of allowing me to come and testify, opening this Committee to some new thoughts—and some not so new—but thoughts of other people in regard to this whole problem of the delivery of health care services for our senior citizens. It is a very difficult one. But I really believe that if we are going to spend $31 billion, we ought not to be doing it in the one area where the private sector and Medicare are there, and where people have planned and built on that purpose. We ought to then take this $31 billion and look toward long-term custodial nursing home care, where I believe seniors and many families in America would agree, that if we are going to spend our money that this is where it best ought to be spent.

We cannot do it all. We cannot do acute care, in-home health care and also long-term custodial nursing home care. It seems to me we have to pick one of the three and then bear down on that in light of the terrible deficit and the debt problems we have before this nation.

I thank you very much for the opportunity of testifying before you, sir.

The **Chairman**. Congressman Fawell, thank you for your testimony. I understand your concern about nursing home care and the great concern of older citizens about that—that is obviously a major priority. But in trying to sort out those priorities we look at catastrophic illness and the premium there, and the amount paid, and the $5-6 billion a year substantial controversy. And one of the least expensive nursing home care bills that I have seen here is in excess of $25 billion a year. That is our problem in trying to take care of these concerns.

I also listened to the testimony of the Secretary opposing any delay in the implementation in direct contravention of your position. Then I read his quote here, that these beneficiaries have been asked to contribute to financing the new benefits, that they are still paying far less than the market value of their Medicare benefits. Now that is his statement.

Congressman **Fawell**. May I say in reference to the cost of long-term care, I recognize having a mother-in-law in a nursing home at this point—and we do pay approximately $2,500 per month—it is very expensive. I do not, by any means, mean to imply that the Federal Government ought to pick up, or any one group pick up, the total cost. If we could, for instance, think in terms—and this is just one concept—of having a 2-year deductible in allowing the private sector or various modes of legislation with credits that one can have for savings and things of this sort, to be able to pick up the first 1 or 2, or maybe even 3 years. But at least have us move in the direction of Medicare. If it is going to expand, to expand in the area which is the dire first trade high priority need of most Americans.

This is where I believe we failed them. We did not realize that as good as what was passed it was not what they wanted. And then I think when we say to them you are going to pay this, and not only are you going to pay it, you are going to have to subsidize others less fortunate than you—all our hearts go out to those who are less fortunate—then I think we owe it to them to give them what they most want in a program like that.

In reference to the fact that this still is a good deal in terms of total Medicare benefits, I would agree, I suppose at this point. Although everybody has different actuarial determinations. But all of the people who are on Medicare and Social Security have relied upon, for instance, what is there right now—not necessarily as a gift or whatever one may want to call it. But it is there and they geared their whole retirement and their later years to that. They did not foresee that there was going to be a special income tax, which you and I know, once it is there it is going to go on and on. They did not foresee that.

And for the average middle-income American—people who have taxable income of $10,000 or $15,000 or $20,000 or $25,000 which is less and less today to be able to meet the exigencies of life in general—this tax is big bucks. They simply have come back to me time and again and said, why did you call catastrophic that one area where at least we do have Medigap coverage, we do have a policy of employers providing health care coverage, we do have the ability to go out and buy the insurance? On long-term care we are dead in the tracks. It is not covered by private insurance or Medicare.

We cannot finance both. We cannot go down the acute care hospital physician and then a budget-busting drug program and also expect to have enough money left over to go toward covering long-term custodial care.

The CHAIRMAN. Thank you.

Congressman FAWELL. That is the point I wanted to try to bring home to you.

The CHAIRMAN. Thank you. Thank you, Congressman.

Were there any further questions?

[No response.]

The CHAIRMAN. If not, thank you for your presentation.

Congressman FAWELL. Thank you.

The CHAIRMAN. Senator Levin, if you would proceed and Senator McCain. Is this a duet? All right, fine.

Senator Levin.

Senator McCain. I am glad to follow my distinguished colleague, Mr. Chairman.

STATEMENT OF HON. CARL LEVIN, A U.S. SENATOR FROM MICHIGAN

Senator LEVIN. Thank you, Mr. Chairman. First, let me thank you for holding these hearings. It is a very important step and there is a lot of people who are grateful for your doing this.

The program that we put in place, the catastrophic program, is an important program and it provides important benefits. The way in which we financed it is unfair. We have got to try to find a way that we can correct that unfairness.

I think it is the only program, the only instance, where we offer benefits to a group within society and require one portion of that group to subsidize another portion of that group. Now there may be other instances, but I cannot think of any. For instance, we do not require financially well off veterans who are receiving service connected disability compensation and no other tax payers to subsidize less well off veterans for their compensation.

I think this is what is really eating seniors, is that they have been singled out for this kind of an approach. We are requiring better off senior citizens and no other taxpayers to subsidize the benefits going to other senior citizens of more modest means.

I believe, Mr. Chairman, that senior citizens are willing to share the burden but that they do not want to be singled out because of their age, to shoulder the subsidy for other seniors who are involved in this program.

What is more difficult than to understand the outrage, is to find a way which retains the benefits of this program in a fiscally sound way. Senator Harkin and I, yesterday, announced that we would introduce a bill which would do that. It would repeal the supplemental premium and would raise general revenues on top of the basic premium in a way which ensures the financial solvency of the program.

Mr. Chairman, I would ask that Senator Harkin's testimony be made a part of this record.

The CHAIRMAN. Without objection, that will be done.

[The prepared statement of Senator Harkin appears in the appendix.]

Senator LEVIN. Our bill does the following: It would amend current law to keep the marginal income tax rate at 33 percent for families of four, for instance, with taxable incomes over $208,000; or for singles with taxable incomes over $109,000; instead of allowing that marginal rate to drop back to 28 percent, as is provided in current law. This proposal, just maintaining the 33 percent bracket for the wealthiest 1 percent among us, would generate enough revenue from 1990–1994 to make up for the repeal of this income tax surcharge that we have now imposed upon seniors.

Another advantage of this proposal, by the way, is that the maximum capital gains rate under the proposal would be reduced from 33 to 28 percent. So applying the 33 percent marginal rate to families of four with incomes above $208,000 and singles with taxable incomes above $109,000 actually affects only 1 percent of our taxpayers—that is about a million of our wealthiest citizens—and would provide tax relief to 13 million seniors who now are paying this tax surcharge.

I would emphasize, in terms of equity and fairness, these million—those who have joint income above $208,000, families of four; or singles with $109,000—actually are paying a lower marginal rate under the current anomalous law than those that have lesser income.

That legislation to be introduced by Senator Harkin and myself is an equitable way of funding this program, which is an important program. It would cure an anomaly in our tax law which has our wealthiest paying a lower marginal tax rate than those who are less wealthy. It would do both at the same time.

Now I do not think most Americans want to see a general tax increase and our bill does not provide for that. I do believe that most Americans would support eliminating that anomaly in the Tax Code, which has people earning $80 million, for instance, paying a lower marginal tax rate than people earning $80,000. I believe that most Americans would also support applying the revenue generated from that change to achieve any number of purposes, including equity for seniors that our bill would provide.

I see my time is up. Again, I thank the Chair for holding these hearings and I also thank Senator McCain for his letting me go ahead of him.

The CHAIRMAN. I have no questions. Senator Rockefeller, do you have any questions?

Senator ROCKEFELLER. Mr. Chairman, to Senator Levin, we did after all have a decision made by the President that he would veto any catastrophic care bill that was not self-funded. That was not frivolous; there was no particular concern on anybody's part to challenge that because that seemed to be very deeply felt. So then the question came, how else could you do it. Now, it is going to be self financed and 61–63 percent of the people are paying only $4 a month deducted from the Social Security check. The people say they should have a choice not to enroll. If there was a choice, of course, a lot of people would choose no and there would not be this sort of basic financial kitty from which to pay the catastrophic care when it was needed.

Then over and above the $4 premium, the Congress decided, in a progressive manner, that those who make more among seniors who are beneficiaries, should pay more—those who make more should pay more. That is sort of an American tradition. I happen to agree with you that the 33 percent tax level for high income for a tax rate is desirable. I have voted for it every time it has come on the floor of the Senate. I think it is ridiculous that the upper 1 percent should be paying the same as school teachers, for example.

But given that this program had to be self-funded, given that through payroll taxes and general revenue beneficiaries on average pay some $2,600 less than their Medicare insurance coverage is actually worth—of which I thoroughly approve—given the fact that we have 37 million uninsured in this country, given the fact that we have no long-term health care program in this country, given the fact that we have no childcare program in this country—and you are talking now of billions and billions and billions, tens, hundreds of billions of dollars, you want to go back to the general revenue, subject to a point of order, almost certainly vetoed by the current President of the United States.

I mean, I like your thinking. Because it takes burden off of the beneficiaries. But I simply ask you, is it practical in terms of what yet needs to be done? In other words, if somebody is making—a married couple—$75,000 and up, under this supplemental premium, they are going to pay $66.67 more per month. That, plus the $4. And why shouldn't they? Somebody making $75,000 or more, they should. That is progressive taxation. That is what this country is all about.

Now you say go back to the general revenue fund. But then when daycare comes up, when long-term comes up, when uninsured comes up, what well are you going to go back to? And knowing full well that what you suggest is going to get vetoed by President Bush and, therefore, no program. I just wonder about your response.

Senator LEVIN. I think this is a very practical solution, indeed. We have not been able to put together a constituency to extend the 33 percent bracket to upper income Americans. They are actually paying lower marginal tax rates than people earning less. We have not been able to win that vote, even though you have voted for it, and I have voted for it, and others have voted for it. We have never been able to put together even 50 votes for that kind of a progressive system. That is not even progressive; that is just, to me, common sensical. But in any event, we have never been able to put together the votes.

I believe we now have a constituency to help us get over that hurdle. I think there is so much upset over this system of financing, where seniors are singled out to pay the subsidy. I am all in favor of progressive taxation. I always have been in favor of it. But progressive taxation for all of us—all of us—we have never—as far as I know, maybe staff can dig up other examples—we have never said that where a subsidy is going to be provided to some that the people who would pay that subsidy would be limited to the same group.

If there are seniors who should get a subsidy here, and there are, for this program, why should other seniors be the only ones required to pay that subsidy? Why are they singled out to pay that subsidy? We have not done it that way for veterans or students or any other group, require a subsidy. It is not just the members of that group who are stuck with paying the subsidy for those who need; it is the entire population that has paid the subsidy. That is what is novel about this approach. This is groundbreaking. I believe it is precedent setting and it is a mistake.

Now, you say go to the well. I am not just simply going to the general revenue well. Senator Harkin and I, and Congressman Bonior in the House, have introduced a bill which will fund this program in a fair way. It is revenue neutral. We hope the President would sign it. It is a different President than the last President. We do not know that he would not sign it. If he would veto it, we hope there would be two-thirds of us that would override that veto. But I think I can give you pretty good assurance that two-thirds of the American people believe that the wealthiest 1 percent of us should be paying at least the same margin tax rate as people earning less than them and that it is a fair use of that additional money to take car of this inequity.

Senator ROCKEFELLER. My time has run out. But I would just ask you one simple question. If the whole thing were able to be funded by a $4 basic premium per month, and obviously it cannot be, if for this $4 a month—$48 a year—deducted from Social Security, granted that is not happily looked upon and in return for that you had the hospital coverage, physician payment coverage, the nursing home coverage, the drug coverage, hospice, respite, medical buy and spousal impoverishment coverage in this new program, would you say that would be a pretty good buy, if it could be funded just by the $4 per month?

Senator LEVIN. Probably. I think it would be, but it cannot be funded by $4 a month.

Senator ROCKEFELLER. I understand but I think you just violated your principle.

Senator LEVIN. I do not think so. We are talking about who should pay a subsidy for a part of a group. Should that subsidy be paid only by other members in that group when society has made the decision to provide the subsidy? I cannot think again of another example where we have approached the law that way. I cannot think of one example where we have done it.

Seniors are being singled out here because of their age to provide the subsidy to other seniors who are getting, in effect, a subsidized insurance policy. That is what has happened here. It is precedent setting and I think it is inequitable and we ought to correct it.

Historically, you are correct, I know, as to how we got into this situation. The President said he would veto it; it was the only way we could do it. But that is the historical explanation. We can cure this inequity even though your explanation is accurate as to how we got into the situation.

Senator ROCKEFELLER. Thank you, Senator.

The CHAIRMAN. Thank you, gentlemen.

Senator Durenberger.

Senator DURENBERGER. No questions.

The CHAIRMAN. Thank you very much, Senator Levin.

Senator LEVIN. Thank you, Mr. Chairman.

The CHAIRMAN. Senator McCain, we are pleased to have you.

[The prepared statement of Senator Levin appears in the appendix.]

STATEMENT OF HON. JOHN McCAIN, A U.S. SENATOR FROM ARIZONA

Senator McCAIN. Thank you, Mr. Chairman.

If could just add onto the question of my friend from West Virginia, if I could have his attention. The fact is, that if you left the present premium addition of $4 in Part B you would preserve the key and essential aspects of catastrophic health care. And those, in my view, are three: long-term hospitalization, skilled nursing, and spousal impoverishment.

Without the additional premiums, Mr. Chairman, you could provide that coverage for seniors, according to CBO and the estimates that we have. So I would hope my friend from West Virginia would look very carefully at doing what I have proposed, and that is stripping out the rest and in my view, unnecessary aspects of this bill; preserve those three key elements; and then we would not be faced with this incredible burden that we are placing on seniors.

Mr. Chairman, I would like to thank you for the opportunity of being here. I ask unanimous consent to include the testimony of Senator Hatch, Congressman Tauke, some letters that I have received from senior citizens groups, as part of the record.

The CHAIRMAN. With just one caveat.

Senator McCAIN. Yes, sir.

The CHAIRMAN. A few selected letters you are talking about.

Senator McCAIN. Well, Mr. Chairman, if this concerns you, I would ask unanimous consent——

The CHAIRMAN. Senator, we have all received bundles of letters. I just want to understand how far we are going in the record.

Senator McCAIN. All right. Thank you, Mr. Chairman——

The CHAIRMAN. With your good judgment and limitation. All right. Thank you.

[The documents appear in the appendix.]

Senator McCAIN. Thank you, Mr. Chairman.

I think the attendance here today and the attention that we see from the audience is ample evidence that you have taken on a formidable task and for that I am deeply grateful; and I know that seniors all over this country are, that you would take up this issue which is, of course, an extremely difficult challenge.

I agree that the cost, Mr. Chairman, of the act by the way it will be paid for is of concern to seniors. Seniors are saying to me that the mandatory nature of the act and the benefit package it provides is of equal, if not greater importance. Its conversations with seniors in Arizona and the mail that they sent me, including a Wirthlin poll recently conducted, which I would like to provide to members of this Committee that indicate that the seniors are, indeed, overwhelmingly dissatisfied, disgusted and they want something done, and it is not just a reduction of some small percentage of their premiums.

In the eyes of the seniors the Catastrophic Coverage Act is a good idea gone bad. From the onset of the debate over the original Reagan administration proposal, it appeared that there was strong support among the seniors of this country for doing something in the area of catastrophic illness.

Originally, the proposal was to provide seniors with the option of having coverage of long-term hospitalization expenses for only a small increase in their Medicare premium. It also eliminated the co-insurance for hospital and skilled nursing facility services and set a cap on what Medicare beneficiaries would have to pay out-of-pocket for medical expenses. But as the bill moved through Congress, it was amended and amended and amended and we finally ended up requiring seniors to purchase a package which duplicates many of the benefits already available in the private sector.

Thus, not only did the cost increase, but the philosophy changed. It seems that the true issue in this controversy is not the Act's financing principle that seniors should pay for catastrophic illness benefits provided under Medicare. In fact, Mr. Chairman, I think you stated during the introduction and debate over the Senate version that a consensus had developed in favor of the approach that any catastrophic benefits package ought to be paid for by those receiving the benefits. The real issue is that we are forcing the seniors of this country to buy a package of benefits that they do not feel are important enough to pay for.

I have heard from tens of thousands of seniors in my State. Of the 20,000 letters I have received lately, no more than 10 have indicated their support of this legislation. I can tell you their concerns go far beyond merely the amount of money they are paying for the program. Their concerns really cut to the very core of the Act. When I ask people what they thought catastrophic health care should be, they talk about Alzheimer's, they talk about long-term care and that is what they want.

I recognize that long-term coverage is terribly expensive. I have heard some say that it will cost at least $50 billion to do something in the long-term care area. The bottom line is that we may not be able to do a comprehensive long-term program at this time but I believe that some sort of plan that helps make private plans more affordable and accessible to seniors, coupled with some direct public sector assistance would cost significantly less than $50 billion.

It would be nice to develop a comprehensive public sector long-term care program. I think the expense of this bill prohibits us from doing so. The seniors realize this. They are wondering why we spent so much on the benefits provided under the Act when long-term care is the more catastrophic and more costly of the seniors' health care protection needs.

I think their fear, a justifiable one at that, is that the existence of the Act makes it nearly impossible for us to offer anything meaningful in the way of long-term nursing home and home-care assistance in the near future.

Mr. Chairman, I would like my complete statement made part of the record.

I would like to close by saying that we need to roll back the unnecessary aspects of this bill. We need to preserve the critical aspects of it, which are the long-term hospitalization, the skilled nursing home facility, and spousal impoverishment benefits. We could protect those with the present premiums that are there. We also need to have public hearings, not just on rolling back some premiums, but we need to have hearings, Mr. Chairman, on this entire Act itself and whether we need to go back to the drawing board.

Occasionally, legislatures and very intelligent people make mistakes. Mr. Chairman, we made a mistake when we passed this legislation. We need to go back, and in fairness to the seniors of this country who are the ones who are paying for it, revise it and revise it dramatically and do it soon.

I thank you, Mr. Chairman, for your indulgence and your long many year commitment to the issues affecting the seniors of this country and my State and I appreciate the indulgence of the Committee for allowing me to be here today.

The CHAIRMAN. We are pleased to have you Senator.

Are there questions of Senator McCain?

[No response.]

The CHAIRMAN. Thank you very much for your testimony.

Senator McCAIN. Thank you, Mr. Chairman.

[The prepared statement of Senator McCain appears in the appendix.]

The CHAIRMAN. Congressman DeFazio, we are very pleased to have you.

STATEMENT OF HON. PETER DeFAZIO, A U.S. REPRESENTATIVE FROM OREGON

Congressman DEFAZIO. Thank you, Senator. I would like to commend you and the members of the Committee for scheduling the hearing as one of the few, as far as I know, members of Congress with formal training in gerontology, I hope that I can offer the Committee some ideas for how we resolve this problem before us.

I believe there is an opportunity for middle ground. I do not believe that—I would like to recognize my colleague from Oregon, Senator Packwood.

Senator PACKWOOD. Hello, Peter; how are you?

Congressman DEFAZIO. Fine. Thank you, Senator. Thank you for having me here today.

I believe there could be a middle ground between holding the course and retaining the bill exactly as it is and the proponents of outright repeal. The Committee has already heard somewhat contradictory or perhaps confusing testimony from the administration earlier today. We are not quite certain whether or not we really are generating a large surplus in these early years of the program because we do not know what the benefit for the prescription drug benefits and that will cost in future years.

But I think there has been a consistent pattern here in the estimates, and that is that we have overestimated the utilization, and underestimated the percentage of the seniors who will pay the tax, and underestimated the potential surplus here. In my home district, the largest hospital which is a regional hospital in an area was slightly higher than the average of seniors compared to nationally. They did a run of about 5 years of data through their hospital. And they found that one-quarter of 1 percent—not 1 percent, but one-quarter of 1 percent—of their patients could have or would have benefited from the extended hospitalization coverage. This was before the full implementation of the DRG system. They estimate it will be less than one-quarter of 1 percent now.

Official estimates are that 7 percent will exceed the $1370 deductible for hospital bills. I believe that is high. And that does not, or begs the question of how do many seniors find that first $1370. And then finally, the 17 percent that will exceed the $710 deductible for prescription drugs. Again, I question whether or not that is accurate and I do not think the administration has been able to give us solid figures or good data on that.

That is not to say that we should not reform Medicare or that there were not parts of this bill that were good. The spousal impoverishment section, the skilled nursing facility extension, the State buy-in—those were all good parts of the bill as was the establishment of the Medicare Catastrophic Act, the bipartisan commission—the Pepper Commission so-called, after late Senator Pepper.

I believe that therein may lie the answer and the route out of this dilemma, but what we need is some time—some time for that Commission to go forward, to look at a comprehensive solution for those in America who lack adequate health care insurance and bring a proposal, an affordable proposal, forward to us. That is why I have joined with Senator McCain in introducing legislation that would delay further implementation of the program beyond those aspects already in affect and including the spousal impoverishment, and still mandating the State buy-in.

This would delay the implementation of the tax, but earlier. Perhaps the administration backed away today. But earlier the administration said that the additional premium would fully fund the other benefits of the program and not implementing the tax this year would not have a deficit impact this year, unless we are accumulating money for a deficit reduction in this program.

I believe that implementing this sort of a proposal, delaying further implementation of benefits, delaying the tax for 1 year, allowing the Commission to go forward, allowing for more hearings on the part of Congress—the House and Senate—perhaps the House will get up the courage to hold hearings of its own. It was nice that we passed a resolution asking the Senate to hold hearings. I believe we have some obligation in this matter too. And although I do not sit on the Committee. [Laughter.]

And give us a chance with a little bit of perspective to revisit this issue and see if we can improve it and we can reduce the burden of what I feel is onerous tax for the first time in the history of this country—an income tax levied solely against an age group—and I think that is a bad precedent.

Thank you, Senator.

The CHAIRMAN. Thank you, Congressman.

Are there any questions for the Congressman? Senator Durenberger.

Senator DURENBERGER. One question, Mr. Chairman, if I might. To the question, this is not necessarily a good piece of legislation or good coverage, or something like that. I appreciated the fact that you said that there is some good and some bad and so forth. But I guess the question that I ask people, or one of the questions I ask them is, do you really know what you are getting for your money?

You may have been here earlier when I recited some of the current costs of this kind of coverage. I mean we can wish that doctors got paid less or hospitals got paid less, but all have to deal with are the realities. The current cost for Part B only—excuse me, Part A only—the charge that we make to people that have not had Social Security or railroad retirement access into the system—is $156 a month, just to get the hospital part of this. That is $1,872 a year.

Now the total cost, this year, of Part A, Part B, prevention of spousal impoverishment, mammograms, respite care, the incipient drug benefit, if you will, for 60 percent of the beneficiaries is 382 a year, compared to $1872 just for that Part A benefit. For 91.2 percent of Americans, elderly and disabled, the total cost this year for A and B and all those other things is $881.

Now, you know, this did not all come about because of what we did last year. It started in 1966 when others ahead of us began this process of mixing subsidies from taxes, subsidies from premiums and, you know, things like that, into a system which today a lot of the witnesses have said the elderly are unhappy with. I am trying to figure out if you know what it is precisely that they are unhappy with. Are they getting a bad deal at $382 a year, or even at $881 a year? Where is the bad deal in all of this?

Congressman DeFazio. Well, Senator, I think the bad deal is in the levying of a—I mean, there has been a discussion of the number of people uninsured, underinsured in America, but I mean if you look at seniors as a group they are generally better insured than—there are not that many seniors that fall into that 38 million category. So they already do have some insurance. You have raised some excellent points in terms of the value of the program as exists and the costs we are paying. But that is set up by previous policy.

The question is, if we have limited dollars to expend, if the seniors have limited dollars to expend, is this the package that they would ask for, is it the package they need the most, and is this the fairest way to pay for it? I am afraid the answer that I have come to and I think other seniors have come to is, no, no and no.

That is, we do not believe—We are not worried about what happens after 60 days in the hospital, or 60 days plus our lifetime reserve, because with DRGs, if we reach that point we are probably dead for the most part. Not that many people are that concerned about the $1,370 deductible because the real question is, how do they pony up the first $1,370. That is a situation my mother and many of her friends are in as, you know, they will avoid going to the doctor unless they absolutely have to because they do not want to have that out-of-pocket expense until they reach their deductible.

I am not saying we can solve those problems here. You know, I mean, national health insurance. But the question is, you know, with this increase in the premium and with the first time ever age-related premium on income tax, is this the best we could do; and I think no. So I think taking the best parts, keeping those in place, using the existing premium increase to pay for those while we revisit the rest of the benefits and look at whether or not we should levy this surtax would be a prudent course to take at this case in time. And I think we will have better statistics in a year.

If the largest hospital in my District, where we have a higher proportion than average of seniors in the nation, which is a regional hospital, finds that 5 years of computer-generated data show only one-quarter of 1 percent need the more than 60 days, what are the true figures here. I do not think that the administration has totally had its act together in terms of the statistics that have been provided, nor does CBO, apparently, because CBO is bouncing around on whether or not we are generating a surplus.

So there is a lot of confusion.

The CHAIRMAN. Are there other questions of the Congressman?

[No response.]

The CHAIRMAN. Thank you very much, Congressman.

Congressman DEFAZIO. Thank you.

The CHAIRMAN. We will now be hearing from Mr. John Wilkins, the Acting Assistant Secretary for Tax Policy, Department of Treasury. Mr. Wilkins.

[Pause.]

The CHAIRMAN. I would say for the benefit of the other witnesses that when we complete Mr. Wilkins testimony and questioning that we will go into recess until 2:00 this afternoon. We will hear the other witnesses from that point on.

Mr. Wilkins.

STATEMENT OF JOHN WILKINS, ACTING ASSISTANT SECRETARY FOR TAX POLICY, DEPARTMENT OF THE TREASURY

Mr. WILKINS. Thank you, Mr. Chairman. I will submit a statement for the record and I will summarize it in 5 minutes for you.

My statement today is limited to explaining the estimates of the income-related supplemental premium revenues that are the responsibility of the Treasury Department. In June 1988, at the time of the enactment of the Medicare Catastrophic Coverage Act, the administration estimated that receipts from the Act would total $37.4 billion over a 5-year period, fiscal years 1989 through 1993.

These receipt collections include both the flat premiums and the income-related supplemental premiums for the basic catastrophic part of the program as well as the drug part. Flat premiums were estimated by the Department of Health and Human Services and the supplemental premiums were estimated by the Department of the Treasury.

The Treasury's year-by-year estimates, Mr. Chairman, appear in table 1, which is attached to my testimony. These estimates gave rise to the administration's estimate of a $2.1 billion fund balance at the end of fiscal year 1993. That may be compared with the $4.2 billion fund balance that was estimated by the Congressional Budget Office at that time and, of course, was the official estimate used by the Congress.

Estimates of supplemental premium payments under the Act were revised by the Treasury for the President's budget for fiscal year 1990. The revised estimates reflect administration expectations that receipts from the Act will now total $41.7 billion for this same 1989 to 1993 5-year period. This is a $4.3 billion increase over our original estimate. These revised estimates include $28.3 billion of supplementary premiums. These estimates are also shown in table 1.

Our current estimate gives rise, coupled with the spending estimates, to a $6.2 billion fund balance at the end of fiscal year 1993, and this is an increase of about $4.1 billion over the original administration estimate and about $2 billion over the original congressional estimate. The reason we have changed our fund balance estimate is that our estimate of the supplemental premiums has been increased from $24 billion to $28.3 billion. However, almost all of this revision is attributable to a revised estimate of the speed with which we expect the premiums to be collected, and almost none of it is attributable to a change in the liability of the affected taxpayers.

The original June 1988 estimate assumed a relatively small fraction of the additional premiums would be paid in the form of quarterly estimated taxes and, to a lesser extent, in the form of withheld taxes on pensions and wages. Our current estimate, the January 1989 estimate, reflects a reappraisal of that situation—primarily a reappraisal of the use of quarterly estimated taxes and withheld taxes by elderly taxpayers who would be making the additional payments under the Act's supplemental premium provision. This change in the assumed form of payments results in a speedup of collection and, as I said, accounts for virtually the entire increase that the administration is estimating for this 5-year period.

Turning to a comparison of our estimates with the CBO estimates, a comparison of the current Treasury estimate of the supplemental premiums under the act with the current CBO estimate shows that Treasury anticipates collection over the 5-year period—again, fiscal years 1989 through 1993—to be about $2.4 billion greater than does CBO. These estimates, Mr. Chairman, are shown on table 2 attached to my testimony. However, a comparison of the Treasury and CBO estimates of the calendar year liabilities associated with income-related supplemental premiums, which are on the lower half of table 2, show that both the administration and CBO are quite similar.

This demonstrates that the existing difference between Treasury's estimate of $28.3 billion in income-related supplemental premiums over this period and CBO's estimate of $25.9 billion is attributable not to differences in the size of the premium liability, but in differences in the way we and CBO expect the premiums to be collected into the system.

The Reagan administration supported the Medicare Catastrophic Coverage Act of 1988 when it was enacted, as you know, Mr. Chairman; and the Bush administration remains committed to its implementation. The Treasury Department has reviewed the data and the model used to estimate the receipts under the Act and finds no reason to change the estimates that were made last winter and to which I have just referrred.

Although our current supplemental premium liability estimates are not substantially different from those made by CBO, the administration's estimate of actual revenue collections under the Act are $2.4 billion greater than those made by CBO. The administration's $6.2 billion estimate of the overall fund balance at the end of 1993 is not sufficiently large in our judgment, however, to warrant altering the structure of the program's funding mechanism. Treasury would not consider it prudent to alter the premium structure until we have sufficient experience to validate estimates of revenues and spending made by the administration and CBO.

Given the uncertainty inherent in making these kinds of projections in the absence of any significant actual experience and in view of Secretary Sullivan's concern that he expressed this morning that the drug fund may be substantially underfunded, we believe that changing the level of funding now would not be consistent with protecting the rights of the beneficiaries.

That concludes my formal statement, Mr. Chairman. I will be happy to answer your questions and those of the Committee.

The CHAIRMAN. Let me understand what you are saying. Is the administration now saying that there are more funds there than they thought there were going to be in the way of surplus funds a year ago?

Mr. WILKINS. That is right. There will be more funds collected by the Government over this critical period through 1993.

The CHAIRMAN. All right. Then let me ask you this: If that is the case, was the President wrong in signing the bill before when it had a smaller surplus?

Mr. WILKINS. I think the administration was——

The CHAIRMAN. Was he or was he not wrong in signing it when it had a smaller surplus in their mind?

Mr. WILKINS. I do not think he was wrong in signing it, no.

The CHAIRMAN. All right. Then if he was not wrong then, what if these numbers had come in and the numbers had been smaller than you anticipated, we were collecting less than you had anticipated, would you have just said, that is the breaks or would you say, no, we want some fiscal prudence here, so let us increase the premium?

Mr. WILKINS. We'd be a great——

The CHAIRMAN. Now wouldn't you have done that?

Mr. WILKINS. We would be a great deal more concerned than I am today. I am expressing some concern because we do not have the numbers yet. These are still estimates. They are our best estimates, but there is no experience. It is a new program and we are concerned that CBO has different estimates than our estimates. I am not saying that we have to be right and they have to be wrong. But that kind of uncertainty makes me uneasy.

What we are saying is that, given that uneasiness arising from the fact that we do not know with precision what the answers are, it is too early to make a change.

The CHAIRMAN. It is obvious we have some variance. But the convergence of numbers seems to be, and the trend seems to be, by all of these estimating groups, that the money is more than they had figured before. The trend certainly is that way from all of them as I see it.

Mr. WILKINS. As I indicated on the revenue side, which is of course what I am primarily addressing, the liability that we estimate is virtually identical with the liability that the CBO currently estimates. They are only slightly higher over the period. So the only difference between us, the administration, and CBO on this issue is how fast we expect these premiums to be collected by the Government.

The CHAIRMAN. Well, we are going to see, as we hear later from the Joint Tax Committee on some of their numbers, some additional variances that come into this. I am not sure but what CBO is going to find those too as we go along later on, from some of the feedback I am beginning to get.

If we come up with numbers where we feel there is sufficient consensus and there is excess funding, you just think we ought to keep it there; is that it?

Mr. WILKINS. I think we ought to keep it there because it is very difficult for us to know that there is excess funding until we have some actual experience with the program. We will not see, for example, on the tax side the information from tax returns until, at the earliest, the fall of 1990. That is the first time we will have a chance to see the 1989 returns and know how things are actually working, to give us some——

The CHAIRMAN. Well, we are seeing an increase in revenues, whether it be just by an acceleration of collections or as some think—and I think you are going to see testimony—that there are a higher number of those that pay, that are higher income in those brackets than had been anticipated. And what we have further seen is the administration talking—this gets out of your jurisdiction—that the cost of the program has dropped. Now that is the other side of it. Now that is out of your jurisdiction as I understand it; but that is what we have heard from the administration.

That the cost of the program has dropped. So you have yourself more money coming in whether because it is being collected faster or you have a higher percentage of people who have a higher income. You have that going that way; and then we have the cost going down in the estimate. Obviously, you have yourself a bigger surplus—instead of a $4.2 you have approximately twice that in the amount of cushion.

Now we are not just talking about reserves committed to pay the benefits, but we are talking about reserves and a cushion above that. We went to great lengths to try to be prudent in that regard and be sure that cushion was large enough; and now it is approximately twice as much as was talked about. And in addition to that we built in—and I was deeply concerned, as were many of the members of this committee, that we give some flexibility to the administration, that we give them opportunities to correct the course, make course corrections as they found complexities in the program, or costs that were not anticipated.

So that is what we are trying to resolve, is do we need to compound that cushion.

My time has expired.

Senator Rockefeller.

Senator ROCKEFELLER. No questions.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

Mr. Wilkins, see if I can understand the discrepancy in the collections. First of all, as I understand the estimates, the income from the premiums are on target. Where the variation occurs is on the estimates for the supplemental payments. Am I correct there?

Mr. WILKINS. Yes. When you say on target, again, we have no actual experience to speak of yet from this program. Because it is so new we have not seen revenues. But where the estimates are different—where we have changed the estimates—you are right, it is with respect to the supplemental and not with respect to the flat premiums.

Senator CHAFEE. You stuck with your estimates on the premium?

Mr. WILKINS. That is right.

Senator CHAFEE. Okay. Now the estimates on the supplemental are varied and the variation comes there, as I understand it, from the withholding and the prepayment——

Mr. WILKINS. The estimated payments.

Senator CHAFEE. The estimated payments. And so in effect, is it accurate to say what you are doing is you are getting your money in earlier than you would normally get it? In other words, instead of the people paying on April 15 of the following year, they are paying it either through withholding or through estimates in the current year. Is that correct?

Mr. WILKINS. That is correct.

Senator CHAFEE. So your money is coming in faster. Now if that money were not coming during the current year, through the estimates or through the withholding—You mentioned the withholding, did you not?

Mr. WILKINS. I did, although it is mostly estimated—quarterly estimated payments——

Senator CHAFEE. Mostly estimated, sure.

Mr. WILKINS [continuing]. But there is withholding also.

Senator CHAFEE. A few people over 65 who are doing the withholding.

Now if you did not have that prepayment, as it were, would your estimates be accurate by postponing that amount that came in early and having it come the following year?

Mr. WILKINS. That is right. That we would not have made any change in the estimates if I understand your question. The change is not that we are getting more money; only that we are just getting it a little bit faster.

Senator CHAFEE. You are getting it faster.

Mr. WILKINS. We would have had it in the following year.

Senator CHAFEE. So that we are in a constant—if this carries out—we are in a situation where the money is just coming in earlier than you expected as you look out through each year—out through the future?

Mr. WILKINS. That is right.

Senator CHAFEE. The other point I would like to get from you here is, I understand what you are saying is, all of this is estimates. You are getting a little money in now through the withholding or the estimates now—estimated payments. But basically, all of this is conjecture; is that correct?

Mr. WILKINS. That is correct.

Senator CHAFEE. What you think will happen based on however you do your estimation?

Mr. Wilkins. That is correct. It is based on a better evaluation of the population we believe will be paying supplemental premiums, taking a closer look at how they are currently paying income taxes.

Senator Chafee. Okay, fine. Thank you very much.

Thank you, Mr. Chairman.

The Chairman. Are there further questions?

[No response.]

The Chairman. Mr. Secretary, thank you very much.

Mr. Wilkins. Thank you.

[The prepared statement of Mr. Wilkins appears in the appendix.]

The Chairman. It is good to have you. We will stand in recess until 2:00.

[Whereupon, the hearing recessed and resumed at 2:00 p.m.]

The Chairman. The hearing will come to order; conversation will cease.

Our next witness, Dr. Robert Reischauer, who is the Director of the Congressional Budget Office.

Dr. Reischauer, you have heard a lot of conflicting testimony today on projections—in come and out go. We would like to hear your version of it.

STATEMENT OF DR. ROBERT D. REISCHAUER, DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Dr. Reischauer. Thank you, Mr. Chairman. I am pleased to have the opportunity to testify before the committee. With your permission, I will submit my prepared statement for the record and will confine my remarks here to a brief discussion.

The Chairman. Without objection, and without fear of being overruled at the moment. [Laughter.]

Dr. Reischauer. I will provide just a quick summary of the changes that have occurred in CBO's estimates of the expenditures and receipts of the Medicare provisions of the Medicare Catastrophic Act. I will also say a few words about how CBO's estimates might change in the future.

When the Act was passed last summer, CBO estimated that its expenditures over the 5-year period—1989 to 1993—would total $30.8 billion. At that time, the Joint Committee on Taxation and CBO estimated that the flat and income-related premiums would generate some $35 billion. The difference between the receipts and the expenditures was projected to be about $4.2 billion over this period and the contingency margins, both in the catastrophic account and in the drug trust fund in the year 1993, were projected to be close to those specified by the law.

In February of this year, CBO reestimated the expenditures and receipts associated with the Act for our baseline budget projections. These estimates indicated that over the 1989–1993 period expenditures would be $30.3 billion and that the flat and income-related premiums would generate $39.4 billion. The difference between the baseline expenditures and revenues in February was $9.1 billion, or $4.9 billion larger than what had been estimated in June of 1988. This comparison is overstated, however, because the February baseline estimates did not include the drug program's administrative expenditures, while the June 1988 estimates did include these costs.

CBO excluded the administrative expenses from its February baseline, since baseline projections for discretionary spending accounts are, by convention, only made for programs that are funded in the base year—that is, in fiscal year 1989. As you know, no funds were appropriated for the administration of a drug program in this current fiscal year.

CBO now estimates that the drug program's administrative expenses will total about $1.1 billion over the 1989–1993 period. If one adds this $1.1 billion to the expenditure figures I mentioned earlier, the difference between total expenditures and receipts over the 1989–1993 period falls from $9.1 billion to $8.0 billion.

The primary reason why the cumulative surpluses estimated in February are $3.8 billion higher than those estimated in June of 1988 is because CBO has higher baseline estimates of the receipts that will be generated from the income-related premiums.

CBO's February estimates, when adjusted for administrative expenses, imply considerably larger contingency margins than those planned when the Catastrophic Coverage Act was passed. In 1993, these margins will be 72 percent for the HI/SMI account and 77 percent for the drug trust fund, rather than the levels of 20 percent and 50 percent that were anticipated at the time the act was passed.

In the years following 1993, these margins will decline since the act contains a mechanism that will keep the premium rates from rising as long as the contingency margins exceed those established by the law.

A degree of uncertainty surrounds CBO's February estimates because some of the data on which these estimates are based is old and of uncertain quality, because the behavior of beneficiaries and providers could change as a result of the act, and because we have little experience estimating the costs of programs, such as the new drug program.

Therefore, you should expect CBO's future estimates to change somewhat as our databases improve and as we gain more experience with the new services. However, for several provisions of the act, the changes are likely to be marginal. For example, on the receipt side, our current estimate for the flat premium, which is very close to that of the administration, should be fairly reliable since this premium is similar to the existing SMI premium, which we have considerable experience estimating.

On the spending side, CBO's estimates for the added HI/SMI benefits are also likely to be quite reliable. The bulk of these added costs will result from types of services that Medicare has covered in the past and for which we have accurate and timely data on which to base our estimates.

CBO's estimates of the income-related premium are a bit more uncertain, both because incomes are volatile and because we have no experience with an income tax surcharge that is applied to a demographic subset of the population. Currently, a $2.4 billion or 9 percent gap exists between the administration's and CBO's February baseline estimates of the revenues to be generated by the income-related premium over the 1989-1993 period. But this difference is not as significant as it appears.

CBO and the administration are within 1 percent of each other in their estimates of the underlying tax liabilities. The $2.4 billion difference is largely attributable to different assumptions that we have made about the timing of tax payments. As was described to you earlier today, these different assumptions regard expectations about the portion of tax liability that will be withheld from pay checks and paid in a quarterly estimated tax form as opposed to the amount that will be paid at the time the taxes are due in April.

The Department of Treasury has recently provided us with information explaining the new timing assumptions that the administration used in its fiscal year 1990 budget. We found this information convincing and, therefore, CBO will adopt these assumptions in its August baseline update. The new timing assumptions alone will increase CBO's estimate of supplemental premium receipts by roughly $3 billion over the 1989-1993 period. Most of this increase is expected to occur in 1990 and 1991.

The other area of great uncertainty is the cost of the prescription drug benefit. The administration's estimate for the provisions exceeds that of CBO's by some $3 billion over the 5-year period. But this figure, in fact, understates the true difference between administration and CBO estimates. The administration believes that inadequate balances in the drug trust fund will constrain outlays in fiscal years 1992 and 1993. If these constraints were removed, the administration's estimate of outlays for the prescription drug benefit would be $4.1 billion above CBO's estimate for this period.

Differences of this magnitude persist for two reasons. The first is the absence of recent and accurate data on the drug expenditures of Medicare recipients. The second is our lack of knowledge about how beneficiaries and providers might respond to the new prescription drug benefit. Analysis of the new prescription drug data from the 1987 National Medical Expenditure Survey should reduce the first of these problems considerably.

CBO received this data on May 9 and in accordance with Public Law 100-360 will report to the Congress in early July on how these new data will affect our estimates of the prescription drug provisions. While we have not completed our analysis, initial tabulation suggests that we will be revising our estimates for the 5-year period upward by somewhere between $0.5 billion and $1.5 billion. This revision will reduce the current $4.1 billion gap between CBO and the administration on the costs of this drug provision by somewhere between 22 percent and 37 percent.

The net effect of probably the two largest CBO revisions, which are the timing of the income-related receipts and the costs of the prescription drug provision, will be to increase the surplus we estimated in February for the 1989-1993 period from about $8 billion to $10 billion.

In conclusions CBO's revised estimates of the projected surplus will undoubtedly generate contingency margins for the next few years that are above the levels anticipated in the law. However, considerable uncertainly continues to surround these estimates, in terms of both expenditure's and receipts. Should excess margins develop, they will automatically be reduced in the years following 1993 by the provisions that were included in the law.

Thank you.

The CHAIRMAN. Thank you.

Now in order that I can be sure of your points here, when you talk about the basic parts of catastrophic, we are talking about Part A and Part B, as apart from the prescription drugs. Your numbers appear to be quite stable, do they not, between what you had earlier projected and what the projection is now? Is that correct?

Dr. REISCHAUER. Correct.

The CHAIRMAN. You do not have any substantial variance in that, you have a pretty good continuity in so far as that is concerned?

Dr. REISCHAUER. Those numbers changed very little between June of last year and February of this year. We expect them to be relatively stable.

The CHAIRMAN. So it is in the prescription drug part where you have——

Dr. REISCHAUER. The prescription drug area and the receipts.

The CHAIRMAN [continuing]. Do not have the stability and the volatility that you are concerned about, is that correct?

Dr. REISCHAUER. Correct.

The CHAIRMAN. Can you review for us the reserve margins for these benefits that CBO projected, that we would achieve each year when the legislation was enacted last spring? Did the margin seem reasonable then? And let me ask you, how do such margins relate to other problems, like the Social Security Program?

Dr. REISCHAUER. First, the margins in this program are calculated in a slightly different way from the way in which the margins are calculated, say, in Social Security, in the sense that you are taking end-of-year balances——

The CHAIRMAN. You will have to speak into that mike a little better.

Dr. REISCHAUER. Excuse me. I said that the margins are calculated in a slightly different fashion in this program than they are in Social Security. In this program, you are taking end-of-year balances in the trust fund or the relative account and comparing them with the expenditures that have occurred during that year. In the Social Security system, one often takes the end-of-year balances and compares them with the expected expenditures for the following year.

The OASDI system is running large surpluses. As a result, the reserves are mounting rapidly and the margins are large. As you know, those surpluses stem from demographic reasons. The baby boom generation is in its working years now, and the reserves being accumulated will be used for their retirement in the years following 2015.

The CHAIRMAN. Well, let me get you into another point then. You were talking earlier about your July base-line and an even greater build up in the reserve, approaching some $3 billion. Now is much of that, as I understand from you, an acceleration in the collection, is that it? The revenue coming in faster than anticipated.

Dr. Reischauer. None of the change in the Congressional Budget Office estimate between June 1988 and February 1989, is associated with the timing change for the income-related premium. The administration made that change in its 1990 budget numbers, and we were unaware of it at the time. After the Reagan administration budget was released, we were informed of that change in timing and we reviewed the evidence provided to us. It seemed reasonable, and in fact we are likely to adopt that same set of assumptions on timing when we revise our base-line in August of this year.

Over the 5-year period it will add $3 billion to the $8 billion reserve that we showed in February of 1988.

The Chairman. Now do you think that $3 billion additional reserve is necessary to maintain the adequate reserves?

Dr. Reischauer. Your question calls for a value judgment that you as legislators must make, rather than the Director of the Congressional Budget Office. When the bill was enacted last year, you had——

The Chairman. We wanted as informed a judgment as we can make and that is why we call on experts like you.

Dr. Reischauer. When you enacted the legislation last year, you bought a certain amount of risk insurance based on the estimates available at that time.

The Chairman. And we are getting more than that.

Dr. Reischauer. Subsequently, the estimates changed. The amount of risk insurance you purchased has risen rather dramatically. If you thought you bought the right amount in June of 1988, you have too much now. If you were nervous about how much risk insurance you had bought in June of 1988, maybe you are more comfortable now.

The Chairman. I see my time has expired.

On the arrivals, Senator Durenberger.

Senator Durenberger. Mr. Chairman, I have no questions for this witness.

The Chairman. Senator Packwood.

Senator Packwood. I want to make sure I understand something. You acknowledge that the OMB has had to understate the drug benefits because there is no money to spend on drugs in 1993 in OMB's estimate; is that right?

Dr. Reischauer. Yes. The administration expects the revenues flowing into the drug trust fund will be insufficient to pay the full benefits in 1992 and 1993.

Senator Packwood. Now if the monies were there to pay the full benefits, then the expenditures would be higher. You think the amount they have understated is $1.1 billion and they think they have understated it by as much as $2 billion; is that correct?

Dr. Reischauer. If we use the administration's numbers, the difference between their estimates and our estimates of what drug spending will be in an unconstrained form is $1.1 billion.

Senator Packwood. I think they estimate that they would spend $2 billion more in 1993 if they had any money to spend at all. But since they presume that the money has run out for drugs, they presume no spending on drugs for 1993, if I understand what they have done. Do I phrase it right?

Dr. Reischauer. Well, I think I am a little bit confused. Are you talking about the total amount that they say would be spent?

Senator Packwood. Yes.

Dr. Reischauer. I do not have the administration's numbers right here. But those you mentioned seem reasonable.

Senator Packwood. So that in essence, the surplus is not as big as it seems because if OMB could include the estimated spending for drugs in 1993, it would make the surplus smaller than it otherwise appears when they estimate no spending on drugs in 1993.

Dr. Reischauer. If you are saying that if the administration estimated that it had more money in the drug trust fund, it would also spend more money——

Senator Packwood. Yes, that it would estimate more spending.

Dr. Reischauer [continuing]. Then it would make no difference in the estimated surplus until the drug trust fund received over $1.1 billion more in premium receipts.

Senator Packwood. No other questions, Mr. Chairman.

The Chairman. Senator Heinz.

Senator Heinz. Thank you, Mr. Chairman.

If Congress were to decide in line with one of the options that Senator Bentsen and others have proposed—that we should reduce the premiums in some way, shape or form—so that we only arrived at the contingency reserve level in the funds that Congress originally intended—which was about 20 percent of outlays—what would be the reduction in revenue as to the way we now count the deficit under Gramm-Rudman? What would be the amount of revenue that we would have to otherwise make up or the amount of spending we would otherwise therefore have to cut?

Dr. Reischauer. To maintain the contingency margins for 1993——

Senator Heinz. I am talking about fiscal year 1990, just next year.

Dr. Reischauer. I do not have those——

Senator Heinz. Because we have to do reconciliation in this Committee in short order.

Dr. Reischauer. Right. Although I do not have those numbers at my fingertips, I can say that by 1993, you are talking about a revenue reduction in the aggregate, over the 5-year period, of something on the order of $3.9 billion.

Senator Heinz. For the——

Dr. Reischauer. For the sum of those years.

Senator Heinz. For the 5-year period, $4.5 billion?

Dr. Reischauer. Yes. I would be glad to provide the other numbers for you in short order.

Senator Heinz. All right. That is fine; that would be helpful.

Now secondly in your testimony, where you indicate you have revised your cost of the drug benefit up somewhat by—or you will be revising it——

Dr. Reischauer. We are in the process of doing the analysis right now.

Senator Heinz. To between $.5 billion and $1.5 billion over that same 5-year period?

Dr. Reischauer. Over the 5-year period.

Senator HEINZ. Do those revisions take into account any of the factors that you mentioned in your testimony on page 12, such as drug companies stimulating demand by advertising to Medicare enrollees, new drugs being developed that had been previously considered too expensive, physicians becoming less price conscious and so forth; will those estimates include those factors or will those still be outside of your estimates?

Dr. REISCHAUER. The new estimates that we release will not take those factors into account. We will not incorporate assumptions on those items, the primary reason being that people really do not know what they can reasonably expect.

Senator HEINZ. So those remain uncertainties?

Dr. REISCHAUER. Uncertainties, yes.

Senator HEINZ. None of them are likely to reduce costs, however? To the extent they are factors at all, are they factors which will increase costs?

Dr. REISCHAUER. They are on the positive side. They will increase costs.

Senator HEINZ. What, in your judgment, is the most critical factor in any estimate having to do with the increase in the cost of the prescription drug benefit? Is it most sensitive to increase in price per prescription, number of prescriptions used by people crossing the threshold, what is its sensitive areas?

Dr. REISCHAUER. Any estimate certainly is very sensitive to increases in the prices of prescriptions. But we know how prescription prices have been behaving over a long period of time. We have good data in the consumer price index and elsewhere on drug costs. One would not, therefore, expect radically different kinds of numbers to come out.

One critical area of concern is the extent to which there will be any induced demand from this kind of benefit. The administration is predicting considerable induced demand. In the Secretary's testimony, I believe he mentioned 10 percent the first year, 12 percent the second year, and 11 percent the third year. CBO's estimates are substantially below that. We regard the threshold of $600 to be quite a hurdle. There is also a hefty co-insurance rate of 50 percent, which declines to 20 percent.

Senator HEINZ. Let me just sum up because my time is about to expire. In sum, what I think I have heard you say—and correct me if I am wrong—is that if we cut the premiums so that there was only the 20 percent contingency over the next 5 years, in each of the next 5 years, the amount of premium reduction or revenue foregone to the Government—I think it is the same thing in this case—would be about $3.9 billion.

Second, you anticipate an increase in the cost of the prescription drug benefit somewhere between $.5 billion to $1.5 billion. And thirdly, that omits certain factors that are highly speculative, nearly impossible to calculate on the basis of any evidence. But which, if they materialized, would have further impact on the cost in an adverse way.

Is that a fair summation of what you have said?

Dr. REISCHAUER. I think it is fair. I would just add one caveat—namely, that the 20-percent contingency margin is for the SMI/HI account. The drug portion through 1993 has a higher contingency margin specified in the law. It declines to 50 percent in 1993 and then down, so you would have to make some adjustments for that.

Senator HEINZ. Whatever that contingency margin would be, that is what we would bring it down to for the purpose of the discussion. So the numbers are accurate even if I was not?

Dr. REISCHAUER. Right.

Senator HEINZ. All right. Thank you very much.

The CHAIRMAN. Thank you.

Senator Durenberger.

Senator DURENBERGER. No questions, Mr. Chairman.

The CHAIRMAN. Thank you very much for your testimony.

[The prepared statement of Dr. Reischauer appears in the appendix.]

The CHAIRMAN. Our next witness will be Mr. Ronald Pearlman, Chief of Staff, the Joint Committee on Taxation.

Mr. Pearlman.

STATEMENT OF RONALD A. PEARLMAN, CHIEF OF STAFF, JOINT COMMITTEE ON TAXATION

Mr. PEARLMAN. Thank you, Mr. Chairman. I appreciate being here today. I do not have an additional written statement. We have provided the members with a hearing pamphlet which is captioned "Overview of Present Law and Estimated Budget Effects of Catastrophic." You should have that in front of you. I will make my comments very briefly.

On page 12 of that statement is a table that contains another grouping of numbers—I hate to do that to you—that shows the revenue outlay and net budget effects in each of the years 1989 through 1993, as estimated when catastrophic was enacted under the current CBO estimate and under the administration estimate.

Since my responsibility—the Joint Committee's responsibility—is on the revenue side or on the receipt side, let me simply summarize those numbers. At the time of enactment, the Joint Committee estimated the combination of the supplemental and flat premium to generate $35 billion in the aggregate during the 5-year period, 1989 through 1993. The current CBO is $4.4 billion higher than that—namely, $39.4 billion—and that is shown in the middle of the page. Let me say, even though that is a CBO estimate, because it is a base-line receipts estimate, it is an estimate with which the Joint Committee concurs. We have reviewed that estimate. We think it is a correct estimate.

And finally, at the bottom of the page, simply note that the administration estimate is that the difference between the receipts at enactment and currently is somewhat higher than the CBO estimate by $2.3 billion, or $6.7 billion total. Now those numbers are fiscal year numbers. That is, they do take into consideration the discussion that both Mr. Wilkins from the Treasury Department and Dr. Reischauer mentioned earlier—that is the phenomenon of withholding and estimated taxes.

At the time that we actually participated in the calculation of the fiscal perimeters of the catastrophic program last year, we did not work with fiscal year receipts, we worked with calendar year receipts. There was a reason for that. The reason was we wanted to avoid those timing uncertainties. We have provided to members, to the Senators, estimates on a calendar year liability basis. Just so everyone understands what I mean, the fiscal year numbers that are contained on page 12 show how much money is projected to come into the Federal Government during the Federal Government's fiscal year.

The calendar year numbers, or what are referred to as the liability numbers, instead project what is the group of taxpayers—the group of elderly—that is responsible for the flat and supplemental premium, responsible for their taxable year, calendar year 1989, calendar year 1990 and so forth.

Now those numbers are not materially different so I do not mean to confuse the discussion by mentioning calendar year numbers. Just to illustrate for you, as I mentioned before, the difference between the estimate on a fiscal year basis between the CBO current estimate and our estimate at the time of enactment was $4.4 billion. The calendar year number is $4.8 billion. So roughly the same. The reason I mention calendar year numbers to you is, if the Committee decides to take an action to change any piece of the funding mechanism of the catastrophic program, our recommendation to you would be to work from calendar year liability numbers because they are more certain for us to project. They are all projections; they are all estimates. But they take out of the process this speculation about timing.

Let me say, Mr. Chairman, that the change from the estimate at the time of enactment and the current estimate, as Dr. Reischauer says, has nothing to do with timing as far as we are concerned. It is not a change in the projection of receipts that is based on when those monies come in. It is a change that is based on the analysis of the liability on the various taxpayers who are subject principally to the supplemental premium.

Pages 14 through 17 of the pamphlet contain updated distribution tables that reflect the new receipts estimates. I am not going to go into the details on those, except to mention two things to you.

First, we have included 1989 and 1993 tables. We tend to find that if you look at a distribution table a few years out, once the program is in effect, you get a little better feel for distribution.

And secondly, when you look at the tables that are contained on page 16 and 17, be aware that even though we refer to distribution on a joint return basis, that with respect to those —and there is a column on those pages that says, "Supplemental Premium Per Enrollee" and then it enumerates dollar amounts on an income class basis. Be aware that in those cases in which both parties to the joint return are in the Medicare program and are paying the catastrophic premium, that you have to double those numbers so the liability on those parties would be higher.

Finally, at the end of our statement we set out in very general terms, not with very much specificity, options that the Committee could take if it chose to change the program. They range from the extreme of repealing the program to fixing or dealing with the income or the receipts pieces of the program. As I indicated, we set those out in very general form and obviously if the Committee decides to move in any of those in any way and those extend to changing the receipts side of the provide, we will be happy obviously to give you some assistance in doing so.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, it is impossible to follow all these tables in the shortness of time. But let me understand, what was the reason for your change—major reason for your change—in your estimate between last year and this year?

Mr. PEARLMAN. All right. First, the change is principally attributable to the supplemental premium. Virtually all of it is in the supplemental premium. And if you look at page 12 you will see that. You will see that the big difference is in the estimate on a supplemental premium. Now the reason for that change is what we now believe was an error in the way we made the estimate. Not a mathematical type error, but an error in the way we distributed the elderly who we anticipated would be paying the premium among income classes.

Now the relevance of that, obviously, is the more elderly that are in higher income levels, the higher amount of supplemental premium they would pay. Unfortunately, information on the number of elderly in different income classes is not very good. We have some tax return information that gives us details on that, but it is not very good information. It is not very reliable. So our estimator sought to combine the tax return information with census information—Bureau of Census information.

And in doing so came out with what they believe was a sensible distribution of the elderly among those income classes. When we went back to do that again at the end of this year, at the end of 1988—now you might say, well, why were we doing it again at the end of 1988. We were doing it at the time for a fairly unusual reason for us. We had been asked by members of the Tax Writing Committees who were on the National Economic Commission to do some work for them that involved the catastrophic program.

When we went back and started doing that work again, we discovered a disparity. That is when we first detected it. About the same time CBO was working on its base-line estimates, they discovered a disparity. And so those——

The CHAIRMAN. A comparable disparity.

Mr. PEARLMAN. A comparable disparity. In fact, what in fact happened was they communicated with us. They said, we think these are the correct numbers. We looked at their numbers; concluded we agreed with them. We thought they were correct. There were very minor differences between us, but not worth talking about. That is how is was detected. But the bottom line is, we think there was an error—an analytical error made in the way the distribution analysis was done last year.

The CHAIRMAN. Now let me ask you, is OMB, Treasury—are they plugged into this one too? Have they considered this variance? Have they discarded it? Have they agreed to it? Have they added it into their calculations, do you know?

Mr. PEARLMAN. To my knowledge, I think they agree with the analysis and as best I can tell, we are not in—there is some very slight difference. But again, I do not think worth us talking about, that we are in agreement. All three offices are in agreement on the distribution of the elderly among income classes. And that as a consequence, the only thing—the only major item on the receipts side that remains an item of disagreement—and I think as Dr. Reischauer said, now a matter of technical disagreement—among the offices is this timing question.

The CHAIRMAN. All right.

Mr. PEARLMAN. To the extent that the CBO moves to agree with the Treasury Department on that issue, I think essentially there will be no disagreement.

The CHAIRMAN. All right. Now, Mr. Pearlman, one of the options to be considered is if we find that there is more cushion than we had originally anticipated, and this Committee should come to a conclusion that that is in excess and that they want to see that there is a reduction in the premium, that is one of the options to consider. You then posed or structured different approaches to it.

I would like for you to bring those out because I have not had an opportunity to read or study this.

Mr. PEARLMAN. Certainly. Sure.

The CHAIRMAN. How low could we reduce the cap——

Mr. PEARLMAN. All right.

The CHAIRMAN [continuing]. On the supplemental premium if we took that approach?

Mr. PEARLMAN. Sure. On the cap, our projection is that if you used all of the excess, that is our assumption—and for this purpose——

Senator PACKWOOD. I did not hear you, use what?

Mr. PEARLMAN. All of whatever is defined as the excess, and that is what I want to focus on.

The CHAIRMAN. That is above the original cushion we were talking about?

Mr. PEARLMAN. That is correct.

The CHAIRMAN. Okay.

Mr. PEARLMAN. If you use all of that for the reduction in the cap, then our projection is—and I have to tell you that, you know, these projections would certainly have to be treated as preliminary—is that we could reduce the cap—and let me just give you the numbers by years.

The CHAIRMAN. Okay.

Mr. PEARLMAN. From $800 to $450—$800 to $450—in 1989; from $850 to $550 in 1990; from $900 to $600 in 1991; from $950 to $700 to 1992; and from $1,050 to $850 in 1993. So roughly, $300 to $400.

The CHAIRMAN. Okay. Now let us take the other one. How low could we reduce the rate of the supplemental premium?

Mr. PEARLMAN. Again, if we assume that you devote the entire amount of the excess to the reduction in the rate—that is, you leave the cap alone—then our projection is—let me say the current rate is 15 percent for 1989. That is 15 percent of $150 of tax liability produces $22.50 per $150 of tax liability. Our projection is you could reduce the 15 percent to 10 percent in 1989. There would be reductions to 17 percent in 1990; 19 percent in 1991——

The CHAIRMAN. Wait a minute. Do not carry me too fast.

Mr. PEARLMAN. Okay.

The CHAIRMAN. What was it in 1990?

Mr. PEARLMAN. Okay. It is 10 percent in 1989; 17 percent in 1990; 19 percent in 1991; 21 percent in 1992; 24 percent in 1993.

These rates may need to be flattened in some years. In other words, it is a crude, sort of an initial analysis. But I think, again, I can say to you the bottom line is, we could adjust those rates so that in each year the rates would be lower than current law, if you decided to use all of that money to reduce the rates.

The CHAIRMAN. All right. Let us look at the third one. How high could we raise the threshold at which people start to pay the supplemental premium?

Mr. PEARLMAN. All right. The threshold which we have done on a 5-year basis—that is, sort of a one time shot—if you reduce the threshold over the current $150—that is, today if you do not have $150 of tax liability you do not pay any supplemental premium—our projection is that the threshold from 1989 through 1993 would be approximately $1,700. So you could raise that threshold from $150 to $1,700, again assuming you use the entire excess to increase the threshold.

The CHAIRMAN. Raise it from what to what?

Mr. PEARLMAN. From $150 to $1700.

The CHAIRMAN. Okay. I see my time has expired.

Senator Durenberger.

Senator DURENBERGER. Mr. Pearlman, let me just ask you to take a look at your table 4 which sort of explains some of the distributional affects. Well, it is actually, I guess, table 3 and 4.

Mr. PEARLMAN. Sure.

Senator DURENBERGER. And for the benefit of those that may not have your testimony, can you just sort of briefly review the impact of the supplemental premium across the various levels of income as well? I do not know where you do that one.

Mr. PEARLMAN. Sure. I think we can do that. I think it is not necessary to review both of them, Senator. I think we can do it with either of the tables.

Senator DURENBERGER. Okay.

Mr. PEARLMAN. So let us use table 3, which is on page 14 and refers to calendar year 1989. What this table shows you is at $100 increments of supplemental premium, that amount of supplemental premium paid by an elderly taxpayer, how many millions of taxpayers would be in those various levels. What it tells you initially is that 19 plus million elderly, that is people participating in Medicare, would not be subject to the supplemental premium at all.

Senator DURENBERGER. Those are the people that are paying about $31 and some cents a month, whatever it is right now?

Mr. PEARLMAN. That I cannot answer you.

Senator DURENBERGER. Whatever the basic rate is—$31 a month.

Mr. PEARLMAN. I am sorry. I cannot respond to your $31.

Senator DURENBERGER. Okay.

Mr. PEARLMAN. All I can tell you is they will not be paying a supplemental premium. I am sorry; I cannot.

That is roughly 58.8 percent of the universe of Medicare participants. Then as you go up the scale people paying less than $100 of supplemental premium, 4 million people; $100–$200 of supplemental premium, 2.8 million people; and then you can just go right down the line. When you get up to the top, there are 1.8 million people that are projected in 1989 to pay the maximum premium of $800; and you can do the same analysis on the 1993 table.

Senator DURENBERGER. Now what is the—Someplace here, and I do not know if it is in your report or somebody else's, we had figures on the approximate—I forget whether it was taxable income or if it was somebody's estimate of what kind of income which included nontaxable income. What is the average annual incomes of persons at the level at which they begin to pay the supplemental premium?

Mr. PEARLMAN. Refer to page 16, which is another table and seeks to do that.

Senator DURENBERGER. Okay.

Mr. PEARLMAN. Now, again, this is a 1989 table.

Senator DURENBERGER. Right.

Mr. PEARLMAN. What this will show you is that—Let us look at the joint return. That is the left-hand column.

Senator DURENBERGER. That is my mother and father like we were talking about this morning?

Mr. PEARLMAN. That is correct.

Senator PACKWOOD. But that income is not what the normal person would call income.

Mr. PEARLMAN. That is right. And I think that is a very important point and I was going to mention that, yes. But let me answer this question first and then I will pick up on that, Senator.

And what this table shows you is that in the income class of $20,000-$25,000 as we define income—and that is a point that is important to make—that is when the supplemental premium on a per person basis kicks in. And anything below that effectively they will not pay. Any income, any supplemental and then as you go up the income ladder in $5,000 increments you see the premium goes up until you get to $80,000 of income and at that point you pay the maximum $66, $67.

Senator DURENBERGER. At about $80,000?

Mr. PEARLMAN. Yes.

Senator DURENBERGER. On a joint return?

Mr. PEARLMAN. On a joint return, right.

Now let me go back to the point Senator Packwood made.

Senator DURENBERGER. Yes, very good.

Mr. PEARLMAN. Except that it intrudes on your time, is that legal here?

Senator DURENBERGER. No, I think it is important.

Mr. PEARLMAN. And it is important.

Senator DURENBERGER. Thank you for clarifying that.

Mr. PEARLMAN. That is because for our purpose we do an income analysis that is different than what a person puts on their tax return. We do that for a reason. Because when we do an analysis for the Finance Committee or for the Congress, we are trying to show to the members what the real economic impact of a change in the tax law is on an individual. And so we look at items of income for that purpose that are not taxable—tax exempt income is a good example.

So when we define income, just for this purpose, we do not include those items. So in our calculation of income you will see in footnote 1 items of income that are not includable as taxable income. Now we think that is clearly the correct answer. That includes the nontax portion of Social Security; it includes a variety of things. We think that is clearly the correct analytical answer. It gives Congress the best analysis on which to make a decision on how to adjust the tax law.

When people look at that on the outside, people are not familiar with this process, and they look at these income levels and then they look at their tax returns and they say, oh my goodness, Congress changed the rules and now all of a sudden there are bunch of things that are taxed that previous were not taxed. We have heard that in connection with supplemental premium. Obviously, I know the members know that, but we have to set the record straight that the Congress did not change the law on the taxation of any items of income. Tax exempt income is still tax exempt; the untaxed portion of Social Security is still untaxed; and you can go down the line.

All this is, is an analytical tool. It should not alarm people that the law has been changed on what they are taxable on.

The CHAIRMAN. Senator Packwood.

Senator PACKWOOD. Ron, first let me go to that chart on page 14. As I understand it, in 1989 almost 60 percent of those over 65, who receive Medicare benefits are going to pay nothing for a supplementary tax. They are going to get an extraordinary benefit and pay no supplemental tax at all.

Mr. PEARLMAN. That is correct.

Senator PACKWOOD. And another 12 percent are going to pay less than $100. So over 70 percent of Medicare enrolles are getting an amazing benefit for next to nothing.

Mr. PEARLMAN. Well, that is what our projection shows.

Senator PACKWOOD. Well, I am sure your projection is reasonably right. It often is.

Do you believe the bulk of the complaints we are getting are from higher income elderly, who are going to be paying $500 or $700, rather than those who are going to pay nothing?

Mr. PEARLMAN. Well, you know, I am not trying to be evasive. I really do not think I can answer. I can tell you that the complaints that we heard—now where do we hear them—we get some letters from people, not nearly what members get, and we get inquiries from members. I think what we are hearing is more a broad criticism, frankly, of the supplemental premium structure. Now, in fact, that may be coming from higher income people. But I have to tell you, Senator, I could not document that.

Senator PACKWOOD. Assuming that people understood the supplementary tax, there is no reason why complaints should come from people who pay nothing?

Mr. PEARLMAN. Presumably that is correct. That much probably is fair to say.

Senator PACKWOOD. At least based upon our normal experience, they do not complain.

Mr. PEARLMAN. Normally that is right.

Senator PACKWOOD. Let me go to your definition of income. Now let us go to an individual tax return. For an average Social Security benefit of about $6,000 a year for an individual, the untaxed portion is about 83 percent.

Mr. **Pearlman**. The untaxed portion is about 83 percent, right.

Senator **Bradley**. Senator, what chart are you on?

Senator **Packwood**. I am on page 6.

Senator **Bradley**. Right. Okay.

Senator **Packwood**. Table 5. And I am looking at the individual tax return.

Senator **Bradley**. Right.

Senator **Pryor**. Bob, would you ask that question again, please. I missed your question.

Senator **Packwood**. The average Social Security benefit is about $6,000.

Senator **Bradley**. Right.

Senator **Packwood**. Then going down to the footnote on table 5, they count as "income" the untaxed Social Security benefit, and by that they mean the part the employer paid plus the interest on it, and that amount is about 83 percent. So roughly I am going to reduce $6,000 to $5,000 to obtain the average untaxed portion of Social Security income.

Mr. **Pearlman**. But just specifically, so there is no misunderstanding, what we mean when we say the untaxed portion is when the recipient actually gets the benefit. As you know a portion of it is currently taxed; a portion of it is not. So that is what we mean when we say the untaxed portion.

Senator **Packwood**. I am trying to go through this list of income categories and I am thinking of the average Jane or Joe who is retired and trying to fit themselves into your income classes based solely on only their income which is taxable. They may have some tax exempt interest, but if they are an average retiree, it is a modest amount. Employer contributions to health plan and life insurance for average retirees are tax exempt. My hunch is that their taxable income is relatively slim.

Mr. **Pearlman**. Yes, I think number one they will clearly have some Social Security benefits and they not be taxed. They may have some tax exempt interest. That is correct. At least on a current basis—well, they could have some life insurance inside built up. But those are probably the two most significant items—Social Security and tax exempt interest.

Senator **Packwood**. And the insurance inside build up is tax exempt. So the average Jane and Joe, looking at these classes of "income," would say, well my income is "X" and they would be including in their mind Social Security and whatnot. They might be off 20 percent on their true taxable income. Is this what the average person would think?

Mr. **Pearlman**. You mean if they think about what——

Senator **Packwood**. If they think what they get as opposed to what would be taxable.

Mr. **Pearlman**. Yes, we will be off. Their view of what their income is will be off, yes, somewhere around 20 to 25 percent, probably.

Senator **Packwood**. So really, as I listen to this testimony, it seems to me those who now have benefits fall into one of two categories. Of these benefits that we are now going to provide, some were paying for them themselves and others were having them paid for by retirement plans of some kind. This last group are paying relatively little for what they think are the same benefits this catastrophic plan gives them that they are now going to have to pay for.

For those in the first group—who are paying for the premium themselves—for the life of me, I do not see how they can get a plan as good as what they can now get from the government, for what they are being asked to pay. I fear they are not going to be paying enough to pay for it eventually. But that is another matter. So the complaints have to be coming from people who already have the benefits in one form or another paid for, by in large, by somebody else.

Mr. PEARLMAN. I do not know about the latter point. I mean I think you are probably right about the former point—that is, obviously people who are paying very little supplemental premium would be likely not to complain. I mean I would take that as a given.

Senator PACKWOOD. There may be some complaints from people who do not have any of this insurance; do not want any of this insurance, and therefore they are going to have to pay for something—something they will get, actually a pretty good plan—but they do not want it. And therefore they do not want to pay for it.

Mr. PEARLMAN. As I said, the only response I can give you – and it is really not responsive—is that the thing we are hearing and it is not, again, it is not nearly representative of what you are hearing, I think, is the fact that it is just a different number than last year. The Congress adopted a program and it looks like the Congress overstated what the premium was needed to fund the program and people are complaining about that.

Senator PACKWOOD. I have no other questions, Mr. Chairman. Thank you.

The CHAIRMAN. Senator Bradley.

Senator BRADLEY. Thank you very much, Mr. Chairman.

Ron, I found the testimony extremely informative, particularly your responses to Senator Bentsen's questions. I would like to just followup on some of the things that he asked and also go back to some of the charts.

Now you did three runs for Senator Bentsen in which he asked you if we took the overestimation that you had in your original projection last year and kept the same cushion that we had assumed in the original bill, but used the excess in three ways, and you gave him a set of numbers. One was how much could we reduce rates on the supplemental, the other was how much could we increase the threshold and the first you gave him I did not get. It was a reduction of what?

Mr. PEARLMAN. The maximum amount of the premium, what is referred to as the cap.

Senator BRADLEY. The maximum amount of premium. Okay, that is the one I missed. I wrote all the numbers down though and now I know what all the numbers mean, except the first number.

Now on the threshold you said that if you took the money you could raise the threshold, from $150 to $1,700 before anyone pays any supplemental premium. Is that correct?

Mr. PEARLMAN. That is correct. Understanding all these numbers are really preliminary.

Senator **Bradley**. Right.

Mr. **Pearlman**. Right.

Senator **Bradley**. Now if I look at table 5 on page 16, just in an eyeball, that would seem to tell me that anybody earning income under about $36,000 would have no supplemental.

Mr. **Pearlman**. Yes. The $36,000 I am not sure of. But I can say this, the information I have in front of me makes it clear that virtually all of the benefit of increasing the threshold goes to people from the income classes of $30,000–$40,000 and below. I think that by definition that means that you are just going to write then off in terms of a supplemental premium.

Senator **Bradley**. Right. My question then is, if 60 percent of the seniors now pay only the basic and do not pay any supplemental, by raising the threshold to $1700, how many more would pay only the basic and no supplemental?

Mr. **Pearlman**. It is going to increase that percentage and it is going to increase it rather significantly. We can give it to you but I do not have it now. I just do not have that number with me.

Senator **Bradley**. Okay.

Mr. **Pearlman**. But we can provide that, if you want them.

Senator **Bradley**. Because as we look at the various options on how we might want to use this additional revenue that seems to be there, clearly one of the options could lead to 90 percent of the population having to pay only a basic benefit. That would be different than 60 percent paying only a basic benefit or 80 percent or 70 percent. So the numbers are important.

Mr. **Pearlman**. Let us give you that information.

Senator **Bradley**. On the maximum premium, you are saying if you took all of the money and simply reduced the maximum premium that the most anybody would have to pay in 1989, whatever their income, would be $450 instead of $800?

Mr. **Pearlman**. That is correct.

Senator **Bradley**. Now if you take those two approaches, the approach of raising the threshold would tend to favor lower income individuals?

Mr. **Pearlman**. That is correct.

Senator **Bradley**. The approach of reducing the maximum premium would tend to favor upper income individuals?

Mr. **Pearlman**. Yes. Although, let me just say—I think that is right. That is an accurate statement. But let me indicate that when we say upper income here you have got to be careful because it is not so upper.

Senator **Bradley**. Upper within a range because the elderly basically have low incomes.

Mr. **Pearlman**. Yes, but the range is fairly low. I just want to emphasize that. For example, if you reduce the cap you start impacting people pretty significantly at the $30,000–$40,000 range and up. So there is a benefit certainly at the middle income that is very significant, if you reduce the cap.

Senator **Bradley**. Well, if you went over to table 3, well, that would get to the maximum premium part.

Mr. Chairman, I think that this is very helpful and it gives us a lot of information that we did not have and gives us much greater flexibility than we thought that we had in the process.

Now, how sure are you that this time next year there will not be another reestimate?

Mr. PEARLMAN. I do not think we are, but I mean I think that is inherent in estimates and it is also particularly inherent in these estimates because as everyone has appeared before you previously has indicated, this is a new program. Let me just illustrate a specific part of the new program from our standpoint, which is the revenue side.

This is the first time, to my knowledge, that the tax system has ever had an income tax surcharge that applies to a small category of taxpayers.

Senator BRADLEY. Right.

Mr. PEARLMAN. So we are guessing here. But having said that—and I want to underline the next point—we do not anticipate material changes in the estimate of the methodological kind that I have reported to you today. I mean that kind of change we do not anticipate again.

Senator BRADLEY. In addition to the income, the percent of the population is an important part of the estimate.

Mr. PEARLMAN. Yes, that is what I meant. Yes, right.

Senator BRADLEY. On your table 5, is there any way that you could chart a fifth column there that would give us a sense of how many people fit into that category so that we could do total population?

Mr. PEARLMAN. Sure. I think we can do that. We will try to do that.

Mr. Chairman, let me make a—do you mind if I make just two very brief comments?

The CHAIRMAN. Fine.

Mr. PEARLMAN. One of the reasons, Senator Bradley, that we encourage the Committee to look at calendar year liabilities—again, I do not think it makes much difference in terms of your decision making, but it makes a lot more difference from our ability to make the statement to you that we do not think we will be coming back changing the estimates a lot next year, because it takes away this speculation about timing—when is the money coming in.

The second thing is, from our standpoint and our ability to give you input, you can pick any number you want. You can say you want to adjust the program by $4 billion or $3 billion or $5 billion and we can back into adjustments to the rates or the cap or the threshold, just as we did last year. So from our standpoint, what we need is you tell us what you want to do aggregate dollar wise. We will then come back to you and say, this is what you can do in terms of an adjustment. There is no magic number from our standpoint. That is a judgment for the members to make.

Senator BRADLEY. Thank you.

The CHAIRMAN. Senator Pryor.

Senator PRYOR. No, Mr. Chairman. I would just like to thank Mr. Pearlman for the very good work up that he has done on this. He may have shed some real light on this subject that I think all of us are looking for at the end of the tunnel. Thank you, Mr. Pearlman.

Mr. PEARLMAN. Thank you, Senator.

The CHAIRMAN. Are there any further questions of Mr. Pearlman?

[No response.]

The CHAIRMAN. Thank you very much, Mr. Pearlman.

Mr. PEARLMAN. Thank you, Mr. Chairman.

The CHAIRMAN. That gives us a better understanding of our options.

[The prepared statement of Mr. Pearlman appears in the appendix.]

The CHAIRMAN. Mr. Robert Myers who is the former Chief Actuary for the Social Security Administration and Chairman of the Commission on Railroad Retirement Reform. Mr. Myers, we are delighted to have you.

Would you please try to hold down the conversation. We have an important witness before us and we want to hear what he has to say.

Mr. Myers.

STATEMENT OF ROBERT J. MYERS, FORMER CHIEF ACTUARY, SOCIAL SECURITY ADMINISTRATION AND CHAIRMAN, COMMISSION ON RAILROAD RETIREMENT REFORM, SILVER SPRING, MD

Mr. MYERS. Thank you, Mr. Chairman. I would like to submit my full testimony for the record and then summarize it.

The CHAIRMAN. That will be done.

[The prepared statement of Mr. Myers appears in the appendix.]

Mr. MYERS. One of the basic principles of insurance is to protect people against catastrophic losses. This is much more important than so-called first dollar coverage, which can easily be met out-of-pocket or by personal budgeting. For these reasons, I very strongly support the objectives of the Medicare Catastrophic Coverage Act, but I believe that some changes are desirable.

I might point out that, as long ago as 1972, I had proposed a catastrophic drug insurance program in an article in the Wall Street Journal. (January 19).

The supplemental premiums, as you well know, seem very inequitable for some high-income persons. They take the view that, in 1989, they will pay $849 more per person, but that the additional benefit protection will have an actuarial value of only about $60. When viewed from this standpoint, the situation seems to be very inequitable.

However, I think that you must look at it in the broader picture of financing of all Medicare benefits. As you know, in Part B of Medicare, at present the general fund of the Treasury puts in $1,004 in 1989 for each beneficiary. When viewed in the light of these two aspects together, the Federal grant for Part B of Medicare and the supplemental premiums, even the high-income people are at least $200 ahead. Therefore, I do not think that they really have a right to say that they are being inequitably treated.

Of course, people who have been getting a windfall or a bonanza for years will often think that it is very unfair when part or all of that is taken away.

The financing of the catastrophic benefits is very complex. I have a chart in my testimony that schematically shows how it operates and you will see that it is very, very complicated. I think that it can be, and should be, simplified. My proposal for what should be done is somewhat like what was done in 1983 when the Social Security financing crisis was solved by a consensus agreement that slightly reduced benefits, slightly increased financing, and together made a very viable and successful package.

What I would do would be to decrease some of the first-dollar benefits and at the same time increase the financing over what was in previous law. Specifically, in the hospital insurance program, I would introduce 5 percent co-insurance per day for the second to the ninth day, and this would meet the entire cost of the HI catastrophic benefit provisions that were added in the legislation last year.

Similarly, in Part B of Medicare, I would increase the $75 annual deductible to $150. As you know, the $75 deductible has been in effect for many years. Unlike most elements in the Social Security and Medicare programs, it is not indexed, so it really has fallen behind what it was in real terms. If the initial deductible were increased to $150 and were indexed in future years, this would meet the cost of all the catastrophic benefits that the legislation last year added to the Supplementary Medical Insurance program.

Now when we come to the Catastrophic Drug Insurance program, I would finance it by continuing the $4 flat monthly premium and by having a supplementary premium which could be at a much lower level than that in present law. I think the level would be somewhere about 7 or 8, percent instead of the 15 percent and more that is in present law.

The final thing that I would suggest to the Committee, and strongly urge, is that regardless of what is done about the supplemental premium, that it be put on a pro rata basis for the first and last years of eligibility, so that you will avoid having Medicare notch-babies, as we unfortunately now have Social Security notch-babies.

Thank you, Mr. Chairman.

The CHAIRMAN. I assure you I do not want any more notch-babies. [Laughter.]

Senator Packwood, any comments as you might have?

Senator PACKWOOD. No. As usual, excellent testimony. I enjoy every time you come here. You are so knowledgeable and you speak English.

Mr. MYERS. Thank you.

The CHAIRMAN. You made some interesting proposals, I must say.

Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, Bob, let me make sure I get this Part A part straight. Are you proposing to leave the deductible at $560 or whatever we have it?

Mr. MYERS. Yes.

Senator DURENBERGER. So there would be, that first day is paid by the person that goes into the hospital?

Mr. MYERS. Roughly speaking, yes.

Senator DURENBERGER. And then on the second through the ninth day, there is a 5 percent co-pay?

Mr. MYERS. Yes, 5 percent of the $560. In other words, $28 a day.

Senator DURENBERGER. Yes. And $28 a day for whatever portion up to 9 days.

Mr. MYERS. Eight days.

Senator DURENBERGER. Yes, for all of the hospital users that would pay for the catastrophic portion of Part A, in your opinion?

Mr. MYERS. I believe so, yes.

Senator DURENBERGER. I think it is very interesting because, frankly, I do not like the $560 deductible. I think that is a little high given some of the realities and I would love to see that deductible down and substitute for it some sort of co-pay so that those who are actually using will contribute to part of the cost of using it.

Mr. MYERS. Yes, I think that is a good idea, and I just did not develop that approach. It would be better to have a lower amount than $560 and then a little higher amount per day for the first 8 or 9 days.

Senator DURENBERGER. Then to make sure we understand—and Bob is right, you do speak English—on Part B, if we doubled the deductible and then indexed it—take it from $75 a year to $150 a year—that would pay for all of the nonprescription drug benefits that we wrote into that bill. It certainly would pay for the $1,370 cap, is that right?

Mr. MYERS. Yes, it would pay for the $1,370 cap, which I think is the primary cost element, and also for the mammography benefit and some of the other things that were added. I think that this change would pay for the entire package, so that the financing then would be neat, clean, and separate.

Senator DURENBERGER. Okay. Do you have, based on your personal experience, and you know how we respect that around here, do you have a reason for suggesting this approach over the premium increase approach and the supplementary premium approach? Why is this a better approach than the one we chose to use?

Mr. MYERS. I think that my suggested approach keeps the financing much neater and cleaner, so that Part A, hospital insurance, is financed directly, the way it is now, by the payroll taxes. SMI, Part B, would continue to be financed from government contributions and the enrollee premiums, and then the new CDI program could be financed partly by flat premiums and partly by the supplemental premiums, which I think is a reasonably fair and equitable way to do it.

Senator DURENBERGER. Mr. Chairman, I asked these questions not just because of the respect that I have for Bob, but because those of us that sit on the National Bipartisan Commission—my colleague from Arkansas and I both sit on the Commission—have to deal with the problem of universal access for everybody in this country, not just the elderly through Medicare but this huge number of Americans who cannot buy into the system under its present costs.

I think that despite the fact that it looks so simple, that I think Mr. Myers has here at least a fair alternative, if we want to use it as an alternative, but it also gives us some other way for all of us to look at—if we are going to go to some kind of national health insurance or universal coverage or something like that, I think, Bob, what you are saying is, we have to deal with the issue of first dollar coverage. That it is possible and it is fair for all Americans to pay a small amount, like $28 a day for a time in the hospital, if in fact that extends catastrophic coverage to a lot of other people.

So what I hear you saying is that as those of us who have a responsibility beyond catastrophic as we look at how we can provide health plans or health insurance for everybody, you are saying that one of the ways to reduce the costs of this is to find some ways that both the premium and the co-pay end so that those who are actually using the system will pay some greater part of it.

Mr. MYERS. Yes, that is precisely my thinking. The name of the game of insurance is really catastrophic and not first dollar. The chart in my testimony, as you will see, shows that the present financing procedures is so complex and confusing. I would like to see it simplified so that people—policymakers, legislators, and the public—can see how the money is going, and not have it be a maze, as it were.

Senator DURENBERGER. Is it your observation, too, that—as it is with mine and my parents and others—for so long we have gotten used to the idea that health plans, unlike life insurance are not really insurance, they are just a way to get to the doctor and a way to get to the hospital and a way to get to whatever other benefits you have. And so somehow or another a whole generation and a half, maybe a couple of generations of Americans, have lost sight of the notation of insurance. That it is there as a financial protection against a loss that cannot be covered out of current earnings or savings?

Mr. MYERS. I agree with you completely, Senator Durenberger.

Senator DURENBERGER. Thank you very much.

Senator BRADLEY. Thank you very much, Senator Durenberger. Those are five bells. Before we go, Senator Pryor, did you have anything. I just wanted to ask Mr. Myers one question.

Senator PRYOR. No.

Senator BRADLEY. Your suggestion is to increase the annual deductible from $75 to $150 for 1990 and then indexing the amount for future years.

Mr. MYERS. Yes.

Senator BRADLEY. You are talking about consumer price index?

Mr. MYERS. Either the general consumer price index or the CPI for physician services.

Senator BRADLEY. So that basically if we ever went back to 1979 and had 20 percent inflation, you are saying that when someone went into a hospital that instead of paying $150 they would pay 20 percent more which would be $180, right?

Mr. MYERS. This deductible is for physician fees, not for going in the hospital.

Senator BRADLEY. For physicians?

Mr. MYERS. Yes, if prices went up 20 percent from 1 year to the next, the initial annual deductible would go up to $180, but I do not think that there would be that kind of a jump.

Senator BRADLEY. Okay. So then your other suggestion is $28 a day for 8 days?

Mr. MYERS. Yes.

Senator BRADLEY. For everybody, no matter what your income is?

Mr. MYERS. Yes.

Senator BRADLEY. In other words, that has to be the increased cost, user cost, essentially $28 a day?

Mr. MYERS. That is correct.

Senator BRADLEY. And that would over what?

Mr. MYERS. That would cover the fact that there is extended hospitalization benefit protection—from the first 60 days, or the first 90 days with some co-insurance, to unlimited hospitalization for 365 days a year.

Senator BRADLEY. So this is an alternative to the present mechanism of financing?

Mr. MYERS. Yes.

Senator BRADLEY. So you would eliminate all of the supplemental and the basics?

Mr. MYERS. I would eliminate the part of the supplemental premium going to the hospital insurance system. That system would continue then to be fully financed by payroll taxes.

Senator BRADLEY. Okay. Thank you very much Mr. Myers.

The Committee will stand in recess until the Chairman returns from the vote.

[Whereupon, the hearing was recess and resumed at 3:18 p.m.]

The CHAIRMAN. This hearing will come back to order. If you will please cease conversation and take seats.

Our next witnesses will be a panel of Mr. Michael Zimmerman, Director of Medicare and Medicaid issues for Human Resources Division of General Accounting Office and Mr. John Hildreth, Director of the Southwest Regional Office of Consumers Union, Austin, Texas.

Gentlemen, we are pleased to have you. Mr. Zimmerman, I believe you are listed as first. If you will present your testimony, please.

STATEMENT OF MICHAEL ZIMMERMAN, DIRECTOR, MEDICARE AND MEDICAID ISSUES, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY ROGER HULTGREN, GAO EVALUATOR

Mr. ZIMMERMAN. Thank you very much. Mr. Chairman, let me begin first by introducing the gentleman to my left, Roger Hultgren. Mr. Hultgren was responsible for our 1986 report on Medigap insurance, and he has responsibility for ongoing studies of the subject that we are performing for a number of Committees in the House.

The CHAIRMAN. Good.

Mr. ZIMMERMAN. What I would like to do is briefly summarize my statement and hopefully it can be submitted for the record.

The CHAIRMAN. It will be. Thank you.

Mr. ZIMMERMAN. Thank you.

[The prepared statement of Mr. Zimmerman appears in the appendix.]

Mr. ZIMMERMAN. We are pleased to be here today to discuss Medicare supplement, or Medigap insurance policies, and how these policies may be affected by the Medicare Catastrophic Coverage Act of 1988. You asked that we discuss how Medicare benefits changed under the Catastrophic Act, how these changes will affect

Medigap policies and what percentage of Medigap premiums are being returned as benefits.

Almost from Medicare's beginning in 1966, private insurance companies have offered Medigap policies to cover some of the outofpocket costs incurred by Medicare beneficiaries. Because of abuses identified in marketing Medigap policies, the Congress in 1980 added a section commonly known as the Baucus amendment to the Medicare law.

This section set forth requirements that must be met before a policy could be marketed as Medigap insurance. Along with setting model standards, the Baucus amendment established loss ratio targets for insurance policies. Medigap policies had to be expected to pay out at least 60 percent of premiums as benefits for individual policies and 75 percent for group policies. The amendment also established Federal criminal penalties for engaging in abusive marketing practices for Medigap policies.

I should point out that Medigap policies were not intended to provide full catastrophic insurance coverage for acute or long-term care. The policies did not limit a policyholder's out-of-pocket expenses for covered services. In addition, Medigap insurers can choose not to insure certain individuals, while Medicare's new catastrophic coverage applies to all Medicare beneficiaries.

Moreover, Medigap policies generally do not cover services beyond those covered by Medicare. The Medicare Catastrophic Act, which became effective on January 1, 1989, significantly expanded Medicare benefits well beyond those previously available through the program and most Medigap policies. The new provisions include unlimited hospitalization, subject only to a single annual deductible, and both skilled nursing and home health benefits were expanded.

Beginning in 1990 Medicare will also cap a beneficiary's out-of-pocket share of approved charges for physician services. New benefits for respite care, mammography screening and outpatient prescription drugs further improve the protection offered by the program.

As a result of the Catastrophic Act, Medigap coverage requirements were substantially reduced. Starting this year, there is no longer any required coverage for Medigap policies related to hospital services. In 1990 Medigap policies will be required to cover only the out-of-pocket limit of $1,295 for Part B services. Without these changes, policies would have been required to cover an amount in the neighborhood of $50,000.

In our 1986 report, we discussed the loss ratios of Medigap policies and reported that most policies we looked at were below the Baucus amendment targets of at least 60 percent for individual policies and 75 percent for group policies. However, the loss ratios of the policies offered by the Blue Cross/Blue Shield plans reviewed, and the Prudential Life Insurance Company, the policies most commonly purchased, were above the targets.

We recently obtained 1987 loss ratio information on 92 commercial policies, including Prudential, and 122 Blue Cross/Blue Shield individual and group plans, which had a total of about $4.9 billion in premiums in 1987. The 1987 loss ratios for the commercial policies averaged 74 percent. However, without Prudential, the other commercial policies' loss ratios averaged about 59 percent. The individual Blue Cross/Blue Shield plans had an average loss ratio of 93 percent and the group plans had loss ratios averaging 96 percent.

For commercial policies, a loss ratio of 74 percent means that for each $1 of premium, $0.74 was returned as claims payments or used to increase reserves and $0.26 represented administrative and marketing costs and profits. By way of contrast, in 1987 for each $1 Medicare spent, about $0.98 was for health care services and about $.02 for program operational expenses.

Mr. Chairman, this concludes my prepared remarks. I will be glad to answer any questions you may have.

The CHAIRMAN. Thank you.

Mr. Hildreth, if you would go ahead now with yours.

STATEMENT OF JOHN L. HILDRETH, DIRECTOR, SOUTHWEST REGIONAL OFFICE, CONSUMERS UNION, AUSTIN, TX

Mr. HILDRETH. Thank you, Mr. Chairman. I appreciate the opportunity to testify before the Committee today on the Medicare supplement insurance market and want to certainly comment on the fine leadership that you have demonstrated on this issue.

I want to share with the Committee the nature and magnitude of the problems in Texas, how regulators have failed to protect the elderly and why Consumers Union believes aggressive steps are needed now to correct those abuses.

The importance of the Medigap market is not in question. In Texas there are an estimated 1.7 million people eligible for Medicare and therefore potential buyers of Medigap insurance. In 1987, elderly Texans paid more than $200 million for Medigap policies. There are more than 120,000 agents who can sell almost 600 different approved Medigap policies in the State.

Present regulation of the Medigap market in Texas has been a failure. Although the State Board of Insurance has been aware of the problems in the Medigap market, it has yet to take decisive action to correct them.

The size of the market and the ineffectiveness of insurance regulation has led to numerous problems for elderly consumers in Texas. First, there is widespread misunderstanding about Medigap policy provisions. Second, many elderly consumers rely on the advice of insurance agents who, intentionally or otherwise, mislead elderly consumers in their purchase of Medigap polices. Third, many elderly send their names to lead developers for information about Medicare, who in turn sell these names to Medigap agents. And fourth, the policies sold are not a fair value because Texas and most other States do not enforce the minimum loss ratio targets enacted by the Baucus amendment almost 10 years ago.

In Texas, because the premium rates of Medigap insurance are not regulated by the State Board of Insurance, the only way consumers are assured that Medigap policies are a fair value is their reliance on the enforcement of loss ratio regulations. Loss ratios in general measure the value of a Medigap policy. Policies with high loss ratios are a better value than those with low loss ratios. According to the 1986 and 1987 reports issued by the State Board, well over one-half of the Medigap policies issued in Texas failed to meet the minimum targets.

While Texas adopted the Baucus standards for minimum loss ratio targets nearly 10 years ago, the Board claimed a lack of legislative authority to roll back rates. Effectively, the Board was hoping the industry would voluntarily comply with the minimum standards. Unfortunately, the industry has not.

Sharp sales and advertising practices dominate the marketing of Medigap policies. Texas has the regrettable reputation of being home to many of the nation's lead developers. Lead developers generate leads or contact lists used by insurance agents to sell policies to clients. The lists, including names, addresses and telephone numbers of elderly consumers, are sold to Medigap agents who use the list to sell elderly consumers Medigap policies. Until recently the State Board has done little to stop the practice of the misleading advertisements used to generate leads.

Texas regulators have also been slow to act in other deceptive practices in Medigap advertising. Consumers Union's Southwest Regional Office collected numerous Medigap ads from newspapers and mailings. These advertisements are a testament to the flood of promotional materials sent to seniors. The ads also show the scare tactics employed to increase sales of Medigap policies. For the benefit of the Committee, we have attached copies of some of those advertisements.

Years of inaction by the Board gave unscrupulous advertisers and lead developers the impression that insurance regulators in Texas could not or would not act to stop deceptive advertising. As a consequence, Medigap advertising in the lead developer industry expanded in Texas. Because Texas is home to many of these companies and does little to stop the unscrupulous ones, other States across the nation are adversely affected.

Legislation backed by Consumers Union and which passed the Texas Senate without dissent was defeated in the Texas House and it would have required preapproval of Medigap advertisements. It would have required Medigap advertisements to give the name of a licensed insurance agent or company. That legislation would have allowed the Board to prosecute those companies sponsoring deceptive advertisements.

Many of the problems associated with the Medigap market happen because of agent misrepresentations or abusive sales practices. The underlying problem of aggressive sales practices is the agent commission structure itself. Medigap agents receive much higher commissions for new sales than for renewals. Therefore, agents have an incentive to encourage the elderly consumer to switch or twist old policies for new ones.

Fundamental to all the problems in the Medigap market is the widespread lack of understanding of those policies. In order for a free market to operate correctly consumers must make and form decisions. There are about 600 different Medigap policies approved for sale in Texas. The policies vary from one another in so many ways it is virtually impossible to compare the value offered by various policies. Sadly, companies succeed in Texas not through selling fair priced and well serviced policies, but through aggressive and misleading advertising and sales practices.

The legislation I mentioned earlier in Texas would have required three standardized policies promulgated by insurance regulators. Standardization is the only way to assure that elderly consumers are able to make and form choices about Medigap policy purchases and are not at the mercy of the agents selling the policy.

Consumers in Texas need meaningful Medigap insurance reforms. Consumers in Texas, like consumers throughout the country, need Congress to take steps to improve the performance of this market.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Hildreth appears in the appendix.]

The CHAIRMAN. Thank you.

Well, Mr. Zimmerman, you are here representing the General Accounting Office, with no axe to grind.

Mr. ZIMMERMAN. I would like to believe that.

The CHAIRMAN. I think that is pretty objective. You made a thorough review of the financial protection that is afforded to older Americans under Medigap supplemental policies. So I am interested in your opinion as to the adequacy of those policies in the absence of the benefits that are now available under the new catastrophic illness program. If the catastrophic illness program that we have enacted had not been enacted, if it were repealed tomorrow—and there are those that want to repeal it, or at least delay it—in your opinion, would private policies provide the same benefits at a reasonable cost?

Mr. ZIMMERMAN. I do not believe so, sir. I think it is very easy for the Medicare program to do it because it has, basically, the whole program as a base. As the gentleman from Texas has pointed out, Medigap policies are sold for profit. The profit is clearly a motivating factor. I just cannot see how, with a wide range of policies that would be available out there that people would expect to get the kind of coverage that the Medicare program offers through a Medigap scheme.

There is no requirement, in most places, that a Medigap policy accept everybody that applies. It is difficult to get a payback of $0.60 on $1 from the policy so you are automatically pretty near doubling the costs of the insurance by going the Medigap route.

So I think it would be much more costly through Medigap and I think it may not offer the same level of services or benefits to all the population that would be available through Medicare. So I do not see it as an alternative at all.

The CHAIRMAN. What is the loss ratio for the average Medigap policy?

Mr. ZIMMERMAN. The average loss ratio is probably, when you include the Blue Cross/Blue Shield plans in with the commercial plans, you are probably in the neighborhood of about $0.70 or $0.75 on $1, or 75 percent.

The CHAIRMAN. And the Blue Cross/Blue Shield, Prudential are amongst those that have the highest——

Mr. ZIMMERMAN. That is correct.

The CHAIRMAN [continuing]. Payback of the premiums collected?

Mr. ZIMMERMAN. That is correct.

The CHAIRMAN. Now let me have the numbers on Medicare and how much is utilized in the administrative costs and what the payback is.

Mr. ZIMMERMAN. Well, Medicare pays back basically $.98 on $1 and $0.02 go to administer the program, not just the carriers and intermediaries, but the operations of the Health Care Financing Administration. An additional aspect is that Medicare reinvests the interest money that it collects into the program. I am quite sure that the Medigap insurers do not turn back the interest they earn on their money toward the program.

It is just a different concept. One is a Federally administered program that is trying to maximize the payback.

The CHAIRMAN. Part of the problem is, a lot of people say, well, look, I already had a Medigap policy. I was already taken care of. I do not need this additional program. Those are some of the letters I am getting. I am just concerned as to those people understanding the extent of their coverage, the adequacy of that coverage, the kind of a loss ratio that is experienced by those policies.

That is why it is important that we have this kind of information available to us.

Mr. ZIMMERMAN. Well, I think it is possible that someone with Medigap policy may have coverage that is equal to what they are going to have via catastrophic; and it is also possible that it may cost the individual less if the former employer pays part of the cost. But I cannot imagine for the 35 million people who would be eligible for Medicare's catastrophic benefit that all these people are going to find a comparable situation across society today. It just does not seem likely to me.

The CHAIRMAN. Well, the experience has not been that the loss ratio is anything like what you have.

Mr. ZIMMERMAN. Well, not only is the loss ratio not similar, sir, but the coverage is not the same.

The CHAIRMAN. That is right. Yes.

Mr. Hildreth, in your opinion, what are the greatest gaps in Medicare coverage for which a beneficiary might want to purchase Medigap coverage and how adequately does the typical Medigap policy cover those gaps?

Mr. HILDRETH. Well, with the Catastrophic Coverage Act, the only basic reason someone might want a Medigap policy is to take care of those excess charges, excess physician charges, to make up that difference between what Medicare will pay, where the Catastrophic Care Act will kick in, and then what those excess charges are.

The real difficulty, of course, is for the consumer making a wise choice about what sort of coverage they need, what options are available and whether or not they can rely on the information that is given to them by agents selling those policies. That has been our chief concern in Texas, that on all three counts, the system, the private sector, has failed consumers in providing them accurate information, in freeing them from deceptive advertising and sales practices, and in selling them policies which are a good value. Because, according to our studies, at least half of the policies issued in Texas have failed to meet the minimum loss ratios established by the Baucus amendment.

The CHAIRMAN. How much did the typical Medigap policy cost before the catastrophic illness program and how has the new law affected the Medigap premiums?

Mr. HILDRETH. I cannot answer. I do not know the answer to that question, but it certainly stands to reason that with the coverage now provided by catastrophic coverage the areas where Medigap insurance policies will kick in have been reduced and therefore the costs should reduce. But they have not gone down. Those premiums have increased, usually because companies motivated by a profit factor have decided to add other provisions, many of which may be provisions the consumer does not need.

The CHAIRMAN. Well, then let me get it this way. What did the typical Medigap policy cost before the catastrophic illness bill? Do you have a feel for that, Mr. Zimmerman?

Mr. ZIMMERMAN. I would say probably in a range of about $600 to $1,500 a year. As the gentleman from Texas has pointed out, in his State, 600 policies are marketed. You know, what is an average policy? It could be whatever you can get people to buy.

The CHAIRMAN. All right. If it was in the area of $600, how would the benefits compare with what we are offering now in the catastrophic illness bill? Could you get a—and I know if you have 600 policies you have a great variance. But can we get some feel of the difference?

Mr. ZIMMERMAN. Well, maybe Mr. Hultgren could shed some light on that question.

The CHAIRMAN. All right.

Mr. HULTGREN. Mr. Chairman, let me try. A recent issue of Consumer Reports magazine just talks about policies being sold now. The premiums range from $40 to $100 per month. Before the Catastrophic Coverage Act, I have seen premiums that were $1,200 a year, and some about $600 a year. Now those policies were not required under the Baucus amendment to cover the Part A deductible. They were required to cover the Part A co-insurance, and a person would not have any liability for that co-insurance, until they had been in the hospital for about 61 days or exhausted their lifetime reserve days. Under the Catastrophic Coverage Act, there is virtually no Part A liability for a Medigap policy at all.

We are doing a study now on Medigap insurance. We have some very, very preliminary information from a couple of States on rate increases. At this point it looks like some policies are asking for increases; some are not asking for increases; and a few are asking for decreases in their premium rates.

Mr. ZIMMERMAN. I think it is interesting to note, too, Mr. Chairman, that starting in 1990 the exposure of Medigap policies, will be pretty much fixed—something in the neighborhood of $1,300 a year, as required by the current NAIC standards.

So people will be out purchasing policies to cover, you know, $1,300, maybe $2,000 worth of expenses. I hope we do not see policies being sold for $1,200 a year to insure people against a $1,300 or a $2,000 expense. But I am not positive we will not see that at this point in time.

The CHAIRMAN. And before catastrophic you could have as many as six deductibles a year as far as hospital bills are concerned?

Mr. ZIMMERMAN. That is correct, sir. You know, the exposure of Medigap policies could be as much as $50,000 a year prior to the catastrophic; and now we are talking in 1990 of a maximum exposure of about $2,000. A significant difference.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman.

I want to go through mother and dad again because it—but the reality is, if you want to know, Mr. Chairman, up until July 1 they were paying $90 a month to get a $560 deductible covered and to get their co-pay covered and my mother was getting $500 worth of drugs. She takes some drugs for cholesterol, or something like that. I tell her to stop eating certain foods, but she wants to take the drugs instead. But they even limit it to that $500.

After the catastrophic bill, it has gone up from $90 to $120.90, or something like that. So I just walked my mother through this whole process, explained to her what to do about the drugs—what she is getting there—and then show her where she gets the deductible and then just say, stop buying this just.

But the problem it seems to me that we have, that these fellows know only too well, is that we cannot even convince our colleagues around here of the value of what we do with Medicare, to say nothing of convincing our own parents. You take one parent at a time and try to work your way through 32 million people, it is very, very difficult. [Laughter.]

It is like forever.

Mr. ZIMMERMAN. Senator, I have a mother too.

Senator DURENBERGER. But I was sort of surprised because when I came on this Committee, you, Mr. Chairman, and our colleague from Montana, whose name is affixed to this Medigap—the Baucus amendment thing—I thought they were sort of nailing this Medigap down. I suppose when you look at it in terms of 1980 it was nailed down. I mean, they got a lot of things you are not supposed to do and things you are supposed to do.

But now I see that Medigap agents—this is from Mr. Hildreth's testimony—"Medigap agents receive much higher commissions for new sales than for renewals. Therefore, agents have an incentive to encourage the elderly consumer to switch or twist."

Well, we are trying to do that same thing here. I mean, we are trying to introduce the notion of annual appraisal of what you are buying. And maybe if you have a choice of products you can buy a better product. So while national policy is trying to encourage people to look at different kinds of ways to buy their health care, you know, out there in the marketplace we also have an incentive system that says, if you can get them out of one product and get them into another product, you are going to get paid more. And that, in and of itself, is fine. If, in fact, the consumer has enough information on which to make these purchases.

I looked through both of your testimonies—and I know they have to be brief—just to see if you have any suggestions for us and for AARP and Prudential—the high class of this whole area—how can you provide the elderly consumer with the kind of information they need so they do not have to call their son on the Finance Committee. [Laughter.]

Or whatever the case may be. I swear, I mean I sit there every year with my mother and I try to understand this stuff. And it is being written by the representatives of the elderly and you cannot understand it. Why is that? Is it impossible to get the point across? We should not have to legislative all this stuff.

Mr. **Hildreth**. If I may respond, unfortunately, I think you will have to legislate something. Our experience in Texas, and what we had tried to address in legislation before the Texas legislature this Spring was very simple. Let us simplify the process for elderly Texans who are looking to buy this insurance through the approval of three standards forms. That is, then they can compare policies between companies based upon price and service, not because of 101 different provisions that exist. So that rather than choosing among 600 policy forms, you choose among 3 and you choose according to the company that offers you the best deal.

We tried to address the issue of commissions. Those agents who sell you a new policy rather than a renewal can do so because the commission on that new sale may be as high as 70 percent. Well, that is quite an incentive not to renew a policy but to sell a new policy and a different policy and to try to encourage that consumer that perhaps they are getting a better deal with this new policy, with a new company. We have asked that we level those commissions on those policies so that that incentive is taken away.

More and more elderly consumers fall victim to well known personalities pitching these insurance plans to them over television. We are just simply asking that advertisements be submitted to the State Board of Insurance—to review them, to make sure they comply with State laws before they are aired or before they are mailed to our senior citizens. We thought they were very simple, reasonable suggestions that would clarify these issues and help consumers make better choices.

Unfortunately, some in the insurance industry decided that that was not the case and they helped to kill that legislation in the Texas legislature.

Mr. **Zimmerman**. Senator, I think what you are probably going to hear, if you brought people in from other States, a difference in performance across States based on the commitment that States have to enforcing their insurance requirements. Some States are very active. I cannot give you the specifics of what they are doing right now. But States like California, Washington, Arizona and Maryland have very active consumer organizations involved in the Medigap area. I think it is one of the down sides that we have a State administered activity. It is basically left up to the States and the same thing—dread disease, and cancer insurance policies, and other policies like that—it is up to the States to determine what to do. That aspect of it was left up to them.

Some States do require preapproval of advertising and some are much more insistent on loss ratios and some handle complaints differently. And again, it is the nature of the system we have set up now, with so much of it left up to the States to deal with.

Senator **Durenberger**. Just one question yet.

The **Chairman**. Yes, by all means.

Senator **Durenberger**. Is there a point at which those of you who have followed this debate would recommend that we, in effect, prohibit insurance as a vehicle for financial protection against deductibles or co-insurance on Medicare? So as long as we have balance billing that is—and we do not cover balance billing in our catastrophic, you might ensure against that. Let us say that we just prohibit in some fashion—I do not know how we do those things. Take away the tax deduction or something like that—prohibit the sale of insurance which only covers the deductible and the co-pay.

Would any of you who follow public policy say that was good public policy?

Mr. ZIMMERMAN. I do not think I can answer that. It sounds like it would be okay, but I am not sure.

What you are saying is that there is not much of basis for insurance—it sounds like—if you have——

Senator DURENBERGER. Yes. If you listened to Bob Myers definition of insurance, which is financial catastrophe, and you get it down about as narrow as we have it now, I mean, there are not a lot of people out there who cannot afford out of current earnings over some period of time to pay the deductible and to pay the co-pays. And instead they are using their co-pay money, or their deductible money, to buy insurance, which only 9 or 10 percent of them use during the course of a year.

We are helping the insurance industry. We are not helping the part of the insurance industry we should be helping. We are helping the Medigap part of it which is a lot of paper processing.

Mr. ZIMMERMAN. Maybe we may want to rethink the position in which we have placed the Medigap policies. You know, they are semi-blessed in their position in our society. After next year, when we are basically talking about covering deductibles, do we feel that that is appropriate insurable activity?

The CHAIRMAN. Thank you.

Well, my friend from Minnesota I think is one of the most knowledgeable men on this subject in the U.S. Congress so I am particularly interested in his concerns.

Mr. Hildreth, from what I hear from you and Mr. Zimmerman, the enforcement of the States is very spotty insofar as trying to aggressively pursue seeing that Medigap policies conform to catastrophic and that you do away with duplicate benefits in trying to hold down these premiums now that the Medigap policy does not have to cover nearly as much as it did before. Is that it? Rather spotting performance amongst the States?

Mr. ZIMMERMAN. Well, I would not go that far, sir. Because it is kind of hard to judge right now since catastrophic just came on line. The insurance companies were required to do certain things. HHS was required to do some things, and adjustments have been made in the requirements that the States are operating under. We are looking at this issue right now to see how well the Medigap policies have conformed to the catastrophic requirements. So I would not want to conclude that they have not.

I think, as Senator Durenberger pointed out, we certainly have a different situation now than we had in 1980 when we enacted the Baucus amendments. And I think, as I indicated to you, some States are just not doing the job as well as others and I think that will come to pass in looking at how the Catastrophic Act affected

Medigap. We will see probably the same thing—some States doing a good job and some other ones not.

Mr. HILDRETH. Some regulation is spotty. I should hasten to add in referring to Texas that the new Chairman of the State Board of Insurance this week asked Governor Clements to include the issue of Medigap insurance in the special session of the legislature which will return on June 20. So there is some evidence of renewed concern there.

But the message is also clear that we need the Congress to stay the course on catastrophic coverage insurance, that it will be of tremendous benefit in providing coverage, heretofore, not held by consumers throughout the country. And that if we have proper regulation at the State level we probably should see lowering of premiums in those areas where Medigap policies can still apply.

The CHAIRMAN. Gentlemen, thank you very much. That is very helpful to us. Thank you.

Our next panel will consist of Mr. Richard Warden Legislative Director for the United Automobile Workers; Mr. Lawrence Smedley, the Executive Director for the National Council of Senior Citizens; Mrs. Lovola Burgess, the Vice President of the American Association of Retired Persons.

Well, I must say, this is a group of heavy hitters. We are delighted to have you. I think we will let the lady go first. Mrs. Burgess since you are prepared to testify.

STATEMENT OF LOVOLA W. BURGESS, VICE PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, DC, ACCOMPANIED BY MARTIN CORRY, DIRECTOR, FEDERAL AFFAIRS

Mrs. BURGESS. Thank you very much. I notice I was put down as Mr. Burgess instead of Mrs. and that is not unusual with a name like Lovola, believe me.

I am Lovola Burgess from Albuquerque, New Mexico, and I am Vice President of the American Association of Retired Persons. I am very pleased to be here today and we are pleased that we have this opportunity to give our views on the Medicare Catastrophic Coverage Act, particularly the issue of excess revenues now being projected for the two catastrophic trust funds.

Before addressing this issue, I do want to thank you, Mr. Chairman, and your colleagues, Chairmen Rostenkowski and Dingell in the House, and President Bush for your continued commitment to the full implementation of the Act. As this Committee knows, AARP did not like the financing requirements that were imposed—specifically that aspect which requires beneficiaries to pay the entire cost of the Medicare improvements—but, like you, we believe that the benefits in the Act are of such importance that they warranted and they continue to warrant AARP's support. As our Board of Directors stated in March of this year, we remain open to new proposals for funding and "will evaluate them in light of their equity and potential for support."

In all the controversy of the Act's financing, it is easy to lose sight of the benefits. When fully implemented, the benefits under the Act will assist almost one in four beneficiaries each year. And over one's lifetime, 75–85 percent of Medicare's beneficiaries will receive help from the benefits in the Act.

While we have heard a lot of criticism about the Act, we must always remember that good governance protects those who are voiceless and helpless. And doesn't that remind us of our dear Claude Pepper and what he tried to do. Not just those who are able to make known their own concerns, but speaking for those who are voiceless and helpless.

This year alone approximately 4 million beneficiaries are projected to benefit from the hospital, skilled nursing facility and Medicaid benefits included in the law.

I know how important these new benefits are in my own family's situation. For example, my 97-year-old mother-in-law has a history of broken bones. She has already been in the hospital twice this year. But under the catastrophic legislation she has paid only one deductible. If her pattern continues, she could be hospitalized several more times this year.

I would like to turn now to the issue at hand. This Committee has asked us to comment on what should be done about the excess revenue now projected from the supplemental premium. AARP offers the following recommendations.

First, we feel that we need to know why and how the revenue estimates changed. Is the change due to new data; a one-time capital gains increase; is it due to Tax Reform; is it new analysts, or techniques; is it a one-time phenomenon? The caution expressed by the President and others should not be dismissed out of hand.

Many members of this Committee, as well as your counterparts in the House, invested substantial time and effort trying to perfect both the benefits and the financing. Likewise, many members of this Committee, as well as the Senate and House at large—and AARP—have borne the burden of criticism and controversy surrounding the financing. It is vital that this Committee get some answers and understand thoroughly the reasons for these new estimates, lest a decrease in the supplemental premium this year be followed by a needed increase a year or two in the future.

Second, if the excess reported by the Chairman can be corroborated, and a solution developed that responds to the excess, it is imperative that this effort not lead to tampering with the benefits. AARP is opposed to any delay or repeal of the benefits in this important Act.

Third, AARP has carefully evaluated and weighed a number of possible options. In carefully reviewing these options the AARP Board of Directors concluded overwhelmingly that the appropriate response, if the excess proves to be real, is to reduce the supplemental premium rate. Under current law the supplemental premium is assessed at $22.50 per $150 of Federal income tax liability in 1989, or 15 percent. This rate increases each year, reaching $42 per $150 of tax liability in 1993, or 28 percent.

Our estimates show that if the excess revenues, estimated to be around $4.3 billion over 5 years, were applied to the rate, it would be reduced to approximately 10.5 percent in 1989 and rise to 19.6 percent in 1993, a drop of nearly 5 percent in the first year and over 8 percent in 1993.

This reduction in rate would mean a reduction in the supplemental premium in 1990 of about $170 for a single enrollee with an income of $30,000; for a couple at $40,000, the reduction would again be about $170; and at $50,000, about $300. This option affects the largest number of beneficiaries on an equal percentage basis, from those paying the least to those paying the most. It maintains the progressivity—that is a word I have trouble with—under the current approach. And while it does not reduce the number of supplemental premium payers, it does slightly reduce the number paying the maximum.

Finally, Mr. Chairman, even as we attempt to grapple with the immediate issue, we must not lose sight of the larger problem of health care costs which affects all Americans, and the problems of access to acute care for some 37 million of our fellow citizens, as well, of course, as the need for long-term care.

It would be easy to attribute the controversy of the financing of catastrophic to only the particulars of this Act, but we know that this is not the case. In study after study, poll after poll, Americans of all ages express concern bordering on alarm at the increases in their health care costs. Employers, too, have indicated their concerns as they watch, despite efforts in some quarters, their health benefit costs rise almost uncontrollably.

AARP believes that the time has come to turn our attention to these needs for they are at the root of many of our current discomforts.

Mr. Chairman, thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mrs. Burgess appears in the appendix.]

The CHAIRMAN. Mr. Smedley, if you would proceed, please.

STATEMENT OF LAWRENCE T. SMEDLEY, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS, WASHINGTON, DC, ACCOMPANIED BY ERIC SHULMAN, LEGISLATIVE DIRECTOR

Mr. SMEDLEY. Thank you, Mr. Chairman. We appreciate the opportunity to testify on the catastrophic health insurance program. I am accompanied on my left by Eric Shulman who is the Director of Legislation of the National Council of Senior Citizens.

Mr. Chairman, the catastrophic health legislation was a well intentioned effort to expand the Medicare program. But, unfortunately, was crafted in conservative, fiscal and economic climate. The result was a bill which does provide some significant benefit expansions without increasing the Federal deficit, but places the entire financing burden of the program on Medicare beneficiaries themselves.

It is this break in the traditional approach to financing Medicare that has resulted in a national clamor among older people to make changes in the financing.

I would like to note for the record, Mr. Chairman, that the National Council opposed the supplemental premium as a financing mechanism for the catastrophic health insurance program from the very beginning.

Nevertheless, the National Council of Senior Citizens remains committed to the implementation of the program and the preservation of the benefits included in the final package adopted by Congress. We do, however, continue to oppose the supplemental premium financing mechanism for the program and believe that alternative revenues must be found as a substitute.

If it is determined there are surplus revenues above the estimates necessary to finance the program's benefits, we believe that this surplus should be returned to beneficiaries in an expeditious and equitable manner.

With respect to any surplus, we believe that some combination of across-the-board rate reductions and an increase in the threshold for paying the supplemental premium should be considered by this Committee. We hope the Committee would not select as one of the options a reduction on the cap on the maximum payments as an appropriate way of returning excess revenues to beneficiaries. Clearly, a reduction in the cap would provide relief only to those Medicare beneficiaries with the highest annual incomes and offer no relief to middle-income elderly taxpayers.

But beyond the question of excess funds, we believe that it is unfair to ask older people to pay the entire costs of the catastrophic health insurance program, just as it is to ask parents of school-age children to pay the entire cost of public schools. Such programs are responsibilities of society as a whole since all of society benefits. Thus, the burden of financing these programs should be shared by all Americans.

The effect of the catastrophic health insurance program is to have the well off elderly subsidize the lower income and poor elderly. Now the National Council strongly supports the concept of the wealthy contributing higher taxes to support government operations and programs. However, we do not believe that this should be done on a generational basis.

The National Council of Senior Citizens believes that the supplemental premiums should be repealed and that revenues should be substituted that are paid for by the population as a whole. This does not mean that we simply want to shift the burden from all elderly taxpayers to all younger taxpayers. The solution we support is far more progressive than that. It is one that would rectify a gross inequity in our current tax system.

As you know, Mr. Chairman, as Senator Levin testified today, under current law, single individuals with incomes between $47,000 and $109,000 and couples with incomes between $79,000 and $208,000 pay a marginal tax rate of 33 percent. Individuals and couples with incomes above these levels see their rates drop back to 28 percent. This is a clear violation of the principle of progressive taxation and beyond the bounds of tax equity.

As we heard this morning Senators Harkin, Levin, along with Representative Bonior, of Michigan, are introducing legislation to rectify this inequity in the tax law and to use the additional revenues to eliminate the catastrophic supplemental premium. The National Council endorses this legislation as a way of broadening the financial responsibility for the catastrophic health insurance program to society as a whole, but doing so in an equitable manner.

The goal of Medicare is to protect older Americans from financial exposure due to illness or hospitalization. It is not to redistribute income or benefits from within one age group. We believe that income redistribution should be primarily carried out through progressive taxation and used to meet our nation's pressing needs. We do not disagree with those who say that the rich elderly should pay more to support our government, but they should do so because they are wealthy, not because they are elderly.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Smedley appears in the appendix.]

The CHAIRMAN. Mr. Warden.

STATEMENT OF RICHARD D. WARDEN, LEGISLATIVE DIRECTOR, UNITED AUTO WORKERS, WASHINGTON, DC, ACCOMPANIED BY ALAN REUTHER, ASSOCIATE GENERAL COUNSEL

Mr. WARDEN. Thank you, Mr. Chairman. Mr. Chairman, my name is Dick Warden and I am the Legislative Director of the UAW. I am accompanied today by Alan Reuther, UAW Associate General Counsel. We are pleased to have this opportunity to share with you and your Committee the UAW's views with respect to the Medicare Catastrophic Protection Act and particularly the financing of that Act.

Let me say at the outset, Mr. Chairman, that we are aware that there are many pieces of legislation that have been introduced to either repeal the catastrophic program or to place a moratorium on its effective date. We are strongly opposed to those pieces of legislation. We believe that when the catastrophic program went through, and we still believe, that the benefits provided by that program are valuable and are benefits that should be retained. So we oppose legislation to repeal or to place a moratorium on the Act.

The UAW commends you, Mr. Chairman, for holding hearings on this issue. We believe that the manner in which the benefits provided under the catastrophic program are financed should be changed and we strongly support the legislation which we understand Senators Harkin and Levin will be introducing to repeal the surtax on the elderly, replace it with general revenues, and raise those general revenues by extending the existing 33 percent tax bracket to very wealth tax payers. We hope that this Committee, and the Senate, will give that legislation favorable consideration.

Mr. Chairman, you have expressed concern about estimates from the Treasury, the Joint Tax Committee and the CBO, which show the revenues expected to be raised by the surtax on the elderly under the Medicare catastrophic program may be larger than originally projected. It appears that the surtax will actually generate a substantial surplus. We agree with you, Mr. Chairman, that this is unfair. If the surtax is not changed, it means that the elderly will not only be paying for the entire cost of the catastrophic benefits, they will also be paying a special surtax to help reduce the overall Federal deficit.

If the Committee decides to modify the surtax on the elderly to eliminate the projected surplus, we hope that you will do it in a progressive manner. The fairest approach, we believe, would be to reduce the tax rate in the surtax or to increase the threshold at which the surtax is imposed. We strongly oppose any effort to simply lower the cap on the surtax. This would give a small measure of relief to the wealthiest senior citizens, but would do nothing for the millions of middle income seniors who are currently subjected to the surtax.

The UAW believes that tinkering with the surtax will not solve the underlying problem in the financing mechanism for the catastrophic program. Like some of the others who have testified today, we object to the principle underlying the financing mechanism—namely, that the catastrophic benefits have to be paid for entirely by the elderly. Requiring the elderly to pay for the entire cost of the catastrophic benefits is, in our judgment, wrong for several reasons.

Most importantly, it violates the social insurance principles that underlie Social Security and Medicare. The UAW is concerned that it could also establish a precedent for other programs which we think would be undesirable. We do not believe that farmers should be required to pay the entire cost of farm programs or that students should have to pay the entire cost of student assistance program, and so on. We think the precedent here is somewhat worrisome and something that we would hate to see extended to other programs.

Requiring the elderly to pay the entire cost of the catastrophic benefits results in middle and upper income senior citizens shouldering the entire cost and paying for the subsidies for lower income seniors. This we believe is unfair. This burden should be properly shared by all of society, not just the more fortunate segment of the elderly.

Because this burden is placed exclusively on middle and upper income seniors, they wind up paying premiums and taxes which are many times the value of the benefits provided under the catastrophic program. Our prepared statement goes into more detail about this.

Beyond fairness in the financing mechanism for the Medicare catastrophic program, the problem is compounded by the fact that many senior citizens already had most of the catastrophic coverage paid for by their former employer. This includes many UAW retirees under our collective bargaining agreements with the major automobile, aerospace and agricultural implement companies.

In our judgment, the legislation which we understand will be introduced by Senators Harkin and Levin represents the best approach for reforming the financing mechanism in the catastrophic program. That legislation would retain all of the benefits added by the catastrophic program. It would also keep the flat premium, which is paid by senior citizens, to help finance the catastrophic benefit. But the bill would repeal the supplemental income-related premium—that is, the surtax—and replace that surtax with general revenues.

In order to raise sufficient general revenues to pay for repealing the surtax, the bill would extend the existing 33 percent tax bracket to very wealthy individuals. The approach adopted by that bill that is consistent with the social insurance principles which have formed the basis for Social Security and Medicare. The Medicare catastrophic program would be financed in much the same manner as the Medicare Part B program—that is, through a combination of general revenues and flat premiums paid by all Medicare beneficiaries.

Mr. Chairman, I would like to take this opportunity again to thank you very much for holding this hearing. Many of our members—many of our retirees—have looked forward to—the opportunity to have their voices heard as part of this hearing.

Our statement is a good deal longer than what I had to say orally. I would like to ask that the statement be included in the record in its entirety.

The CHAIRMAN. The entire statement will be taken in the record.

[The prepared statement of Mr. Warden appears in the appendix.]

The CHAIRMAN. And each of your statements will be in that case. I find them helpful. I know that each of these organizations—whether we are talking about the American Association of Retired Persons, the National Council of Senior Citizens or the United Auto Workers—did not support the idea of the premium being paid by beneficiaries alone.

This Committee and the Congress faced the very strong convictions of the President that it be paid that way or we did not have legislation that he would sign. That was part of the decisionmaking process.

Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, last night as I was preparing for this hearing I got out the list on Senators who voted for this legislation and the Senators who voted against it, and it was just as I recalled it. Those who voted no were Armstrong, Garn, Graham, Helms, Humphrey, Kassebaum, McCain, McClure, Nickles, Roth and Symms. And every one of them I recall talking to. They said, they reason we are voting no is, you are not going to hold the line with your financing mechanism. And one of these days, all of these groups that want somebody else to help pay the bill are going to be in and they are going to break this down.

I am sure it is because a lot of people who are here testifying on this panel were opposed to the notion that anybody ought to pay the cost of their own insurance. That is what I have heard from at least the second and the third witness—that somebody else ought to pay a part of this cost of insurance.

I guess that is the nature of insurance. The folks that live forever pay for those who die early and get the benefit of life insurance; and the folks that get very sick get the benefit of those who stay healthy forever. I just have a little bit of difficulty understanding, particularly with the other hat on that I mentioned earlier—sitting on this Commission that is supposed to meet another objective that I think all three of these people share, which is universal health care in this country.

How in the world, if I adapted to the theories that I have heard in this testimony—that somehow or other those who benefit should not have to pay, somehow we will get somebody else to pay—how we are going to do universal health care in this country. Because somebody at some point, either the—The healthy must pay for the sick. The young must pay for the old. There is always in the nature of a system like this someone else who is helping to take care of the problems of the less advantaged.

There are a series of questions I would like to ask Dick Warden in particular. He talked about the farmers should not have to pay the cost of farm programs and I am tempted to ask him exactly how much of their health insurance that the auto workers currently pay—and it is not a whale of a lot—that is paid largely by taxpayers and automobile buyers, and so forth. It is not paid for by the auto workers. But practically every farmer in America is paying his own health insurance with after-tax dollars, no subsidies, no nothing else.

It would be nice if this Committee could get a little help from the United Auto Workers and others. The Communication Workers, I noticed over the weekend—people who insist on hanging onto this first dollar coverage with $400, $500 health plans, while the farmers of this country cannot afford health insurance and 37 million other Americans cannot afford health insurance either.

And so at some point, without giving up what we have worked hard for, and by God if it were not for the UAW you would not have health coverage at a lot of places. If it were not for the Mineworkers, you would not have it for those kind. We all recognize all of that. But the problem is that at some point, and this was the struggle the Chairman went through last year on this Committee, at some point somebody has to adjust this notion—and AARP I am sure struggled with this—that there is always somebody else out there to pick up this tab. Because at some point it is okay to have a new health plan on top of a very generous existing plan that the beneficiaries pay for.

I just want to know what is so bad about that. I mean, the current subsidy, according to CBO—and I mentioned this earlier in the day—for a 65-year-old person who retires in 1989 and goes on Medicare, that person will get a $2,49 subsidy each year, the rest of their life, from somebody else. This is over and above what he or she paid into the health insurance trust fund. Over and above what he or she pays in on the former premiums—$2649 per year, paid already by somebody else—somebody's kid or grandchild or somebody. And so what is wrong with just this catastrophic —with the respite care, and the mammograms and that sort of thing in there? Suppose if that is all you have to pay that you have to receive, what is so wrong with that?

Mr. SMEDLEY. Well, I do not know whether Dick may want to comment, too. But I would say, first, in regard to beneficiaries paying for it, you have to understand, of course, as you do, Senator, that the basic Medicare program is an insurance program.

The Medicare program is an insurance program. It is a social insurance. It is paid across the board by people who work. It is not put entirely on the elderly. It is the largest of our elderly health programs. Everybody participates; when they become old they participate in the program. You can best finance these kinds of program in that way because nobody bears that much of a heavy burden. Now as far as the catastrophic program, the elderly are willing to pay their share; and you can do it in other ways.

But in this program, you have situations where people—it is not a premium program where people necessarily get the actuarial value. Many people are paying more in premiums than you will get out of the program by far. That is not a good insurance program. You should do it in a more fair way.

In addition, if you were to do it through the Tax Code, along the Harkin bill, you will find out that the people that are in that 600,000 group of extremely wealthy, probably as an average age are probably much older than the typical person in the population. So we do not object to the elderly bearing their burden of this. We just think it should be done in a much fairer and equitable way.

Mr. WARDEN. Let me make a couple of points, too, Senator Durenberger. Under the Harkin-Levin bill, for example, a flat premium would be retained so that the elderly would still be paying for 40 percent of the costs of the program—the catastrophic program. That is modeled much along the lines of the Part B program—where at the current time I think the figures are that they pay about 25 percent of the cost of the Part B program and 75 percent of the costs are paid for from general revenues by the total population. That is what we think should be done in the case of the catastrophic program.

We think the benefits are valuable, just as you do. But our problem is with the financing mechanism and the principle that underlies that.

The CHAIRMAN. I will have to call this to an end because we have a vote and we are about to miss the vote. We will dismiss this panel. I would really like to get into that debate because when you get into the principle of insurance, what we have tried to apply is the principle of insurance here, and it is quite true that some people never get back what they pay into it.

But when I pay on my fire insurance I hope I never have to collect on it and that I am always a loser insofar as the premium paid.

We appreciate very much your attendance and it has been helpful to us. We will take the next panel as soon as we get back from this vote.

We are in recess until then.

[Whereupon, the hearing was recessed and resumed at 4:37 p.m.]

The CHAIRMAN. The hearing will come to order.

For this panel we have Mr. H.T. Steve Morrissey, the president of the National Association of Retired Federal Employees, Washington, DC; Mr. Thomas J. Kilcline, the vice admiral, president of the Retired Officers Association, Washington, DC; Mr. John Adams, the deputy executive director for government affairs, Retired Enlisted Association, Washington, DC; and Mr. Daniel Hawley, president, Seniors Coalition Against Catastrophic Act, Las Vegas, NV.

Gentlemen, we are pleased to have you. Mr. Morrissey, I see you are first on the agenda, if you would proceed.

STATEMENT OF H.T. STEVE MORRISSEY, PRESIDENT, NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES, WASHINGTON, DC, ACCOMPANIED BY JUDY PARK, LEGISLATIVE DIRECTOR

Mr. Morrissey. Thank you, Mr. Chairman. I have a whole statement, with some exhibits, that I ask to be entered and I plan to make some citations from that whole statement.

The Chairman. That will be fine. Please proceed.

Mr. Morrissey. Mr. Chairman, I am Steve Morrissey, President of the National Association of Retired Federal Employees, NARFE, as we call it. With me is our Legislative Director, Judy Park, sitting right behind me.

On behalf of over the 2 million Federal retirees and half million members of NARFE, we appreciate this opportunity to present our views on an issues that has generated more concern, outrage and frustration among the nation's elderly than any other in our memory—the new Medicare catastrophic law.

Mr. Chairman, there is a prairie fire of protests against this new law spreading across this country. It grew out of the grass roots feelings of millions of older Americans that this new law represents a new tax for health care benefits that most already have. Simply put, seniors are saying, it is a new tax and a bad buy.

In the case of the majority of Federal retirees, Medicare catastrophic protection benefits are unnecessary. The Federal Employee Health Benefits Program adequately covers annuitants for these expenses. These retirees gain little and pay dearly under the new law.

Exhibits I, II and III attached to my statement show rising costs for a single retiree and a retired couple over 1988, in 1989, respectively, 135 percent and 142 percent. And while this situation refers only to Federal retirees available data shows that, in fact, 80 percent of the nation's senior citizens already receive catastrophic insurance coverage. The mandatory nature of the catastrophic law shifts that coverage and cost onto Medicare.

Perhaps the biggest casualty of the fallout over catastrophic law will be passage of long-term care legislation. We recognize that any program to cover long-term care will be costly. But we also know that long-term health care coverage is what seniors want, not the expanded acute care coverage that most already have.

NARFE has never advocated that new benefits be fully funded through general revenues, nor have we advocated that the elderly should not share in the costs of such a program. However, we have a responsibility to ensure that if only the elderly must pay, then they should have some choice in the matter. We also recognize the need and responsibility to provide adequate acute care to those who are truly needy. But the cost of providing this coverage should be shared by all taxpayers through a system that assesses the cost fairly, not by a rapidly escalating surtax that imposes the highest income tax rates in the country on senior citizens.

The real problem is the surtax—surtax which is set at 15 percent of tax liability for 1989. It jumps to 25 percent in 1990—25 percent—a full one-fourth of middle income individual's or couples' total tax liability just to pay for the catastrophic benefits.

Mr. Chairman, the outcry against the Medicare surtax is not coming just from the wealthy senior citizens. Despite popular rhetoric, the surtax burden on the truly wealthy is minimal. Exhibit IV is an illustration of this point. It is the middle income elderly with limited tax shelters and deductions who suffer affects of Medicare surtax the most. And, if the current surtax maximum is lowered, as has been suggested, it becomes even a better buy for the wealthy, but middle income seniors continue to bear the full percentage cost, as illustrated in our Exhibit V.

NARFE, along with the Retired Officers Association, was instrumental in setting up a coalition of some 40 organizations which seek reevaluation of the catastrophic law. This coalition for affordable health care evolved in response to concern voiced by millions of seniors.

The coalitions membership points to two things: (1) that the present seniors only mandatory surtax method of financing the benefits is flawed; (2) that the law ignores the real catastrophe the elderly face, which is long-term nursing home and home health care. A recent survey sponsored by the coalition supports these sentiments and will be addressed in more detail by my colleague, Admiral Kilcline, in his testimony.

We believe that all these factors taken together warrant, indeed, demand reevaluation of the catastrophic law. Toward this end, the coalition supports legislation introduced by Senator John McCain, S. 335, and Congressman Peter DeFazio, H.R. 1564. These are identical bills which place a 1 year moratorium on the surtax and on implementation of any further benefits after 1989, giving Congress time to hold additional hearings, reassess the new cost and revenue estimates, and determine the best course of action.

We look forward to working with this Committee, the Congress, and other concern groups to resolve how we can provide adequate acute care to the truly needy and begin providing seniors with the long-term care protection they truly need.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Morrissey appears in the appendix.]

The CHAIRMAN. Admiral Kilcline, if you would proceed, please.

STATEMENT OF THOMAS J. KILCLINE, VICE ADMIRAL, USN (RET), PRESIDENT, THE RETIRED OFFICERS ASSOCIATION, WASHINGTON, DC

Admiral KILCLINE. Thank you, Mr. Chairman.

I represent a fairly large association that works in coalition with several other large and capable associations. The majority of our members are over 64 and on behalf of that group in particular I thank you very much for the invitation today to come and speak with you, and especially for your patience on this long day of hearing.

For several years now Americans have been experiencing a growing concern over the availability of proper kinds of appropriate health care. This concern is greatest among our senior citizens, the group most likely to have health problems, and the group most often faced with the challenge of living on fixed or declining income. These senior citizens have been pressing for a long time for the solution to the disastrous family financial threat from catastrophic health expenses.

When CATCAP, as we call it, was passed, there was a great deal of enthusiasm. At the same time, as you remember, there were some people who had spent some time studying the bill and had some concerns over the financing mechanism. These concerns have developed into an extraordinary expression of opposition that is of such significance and is so widespread that it really has to be considered seriously.

I have submitted a short, and I hope specific statement, which I hope the Committee will read. I plan in my oral remarks to go over and highlight a significant survey to help you understand how we try to define what the elderly are thinking. I would hope that this statement and the report of this study can be included in the record.

In spite of the many stories and articles and editorials covering the issue in recent months, there still has been some doubt as to current attitudes. In order to certify those attitudes, we sponsored a survey by contracting with the Wirthlin Group--one of the most highly respected survey and analysis organizations. They conducted a survey of a cross-section of American citizens over 65—over 1,000 interviews—using 20 questions that we meticulously designed to remove as much bias, doubt and confusion as possible. I would like to go over some of the results of that survey.

The headlines are here to my left. When we started this survey we did not set the stage by telling them what it was all about. The first thing we asked them, what do you think the primary problem is for senior citizens. Forty-five percent (45%) cited health care issues; and of that number, 29 percent included in that number cited health care costs. That is far more than any other concern they have—in deficit or any other problem.

Not only do these senior citizens recognize this as their primary problem, but most of them have done something that I think is astonishing to find from this survey—that 84 percent had some kind of a medical insurance in addition to Medicare. These seniors are representative of mainstream America. Sixty percent (60%) of this group have incomes of less than $20,000. They are concerned. They are not wealthy; they are not even on the average, I do not think you would consider them affluent.

But they have an interesting attitude about who should pay. The majority of them feel that they should be bearing their share of the costs. There are some that do not; but those are the ones who have no insurance and those are the ones who have very small incomes.

By and large our members of this interview group understand what the bill is. Almost two-thirds of them say they understand it fairly well; 44 percent say they oppose it strongly. Given this choice, the seniors that we have surveyed choose their own private health coverage to catastrophic cap legislation.

With all this data, it is not surprising that 55 percent of those surveyed feel that benefits are not worth the costs. The greatest disappointment in the Act as far as most people are concerned is the lack of long-term care coverage. You have heard that before today and I do not think that is a surprise to you at all. A 65 to 19 percent margin prefer long-term health coverage. That really is almost a separate issue, but it does indicate the significance of their concern.

The leaders of our Government recognized for a long time the challenges our seniors face. In their efforts to try to address the problem of catastrophic expenses, they passed an act that we feel missed the mark. They instituted a funding mechanism that is seen as an unacceptable threat. I use the word "threat" because it is more than just this bill. It is a new way of approaching the taxing for the elderly and I think they see that as much of a burden as the actual tax.

In response to some questions about who pays income tax, you take a look at the 60 percent who have income of less than $20,000. Most of us in our associations get around to see our members a great deal. These members understand what surtax means. If they do not pay any tax, they are not concerned about a surtax. The fact that so many of them are concerned indicates to me that they may not be paying a whole lot of tax, but they are paying enough that they feel challenged by it.

They also understand the need for a supplemental insurance program of some kind and although the catastrophic cap does some wonderful things, they still feel a need to have some other coverage. There is still exposure that they have, even after the catastrophic cap, even with Medicare, there is still considerable exposure. It is not just one small item or two items. But when you start totalling together all the different liabilities that they have to pay, including those payments that are above allowable expenses, they could be exposed to several thousand dollars. A couple could be exposed to $3,000 to $6,000. That is not insignificant.

Hopefully, with the controls and such that you are thinking about and the encouragement of the industry, I would think that the insurance programs could be brought under line to take care of those kind of exposures.

There are some military unique inequities involved also, which I hope you have time to consider. Those are in my full statement. But there are things—disabled veterans and military have some unusual problems.

I would like to encourage you to consider Senator McCain's bill S. 335 as a blueprint for an approach to reevaluating the law and identifying the real health care needs of the senior citizens.

I thank you again very much for the time today, Senator.

The CHAIRMAN. Thank you, Admiral.

[The prepared statement of Admiral Kilcline appears in the appendix.]

The CHAIRMAN. Mr. John Adams.

STATEMENT OF JOHN M. ADAMS, DEPUTY EXECUTIVE DIRECTOR FOR GOVERNMENT AFFAIRS, THE RETIRED ENLISTED ASSOCIATION, WASHINGTON, DC

Mr. ADAMS. Mr. Chairman, distinguished members of this Committee, the Retired Enlisted Association is sincerely grateful to the Committee for scheduling these hearings to exclusively hear testimony on the catastrophic health care issue. The Retired Enlisted Association is proud to represent enlisted men and women retired from the U.S. Armed Forces for length of service or those members who are permanently, medically retired.

Today you have heard from witnesses offering a variety of information for your consideration. The Retired Enlisted Association is proud to have been one of the sponsors of the survey described by Admiral Kilcline of the Retired Officers Association.

As you and members of your staff will note, the survey is unbiased and not self-serving, per se. If I may, I would like to be a little bit more parochial, however, in my testimony on behalf of the retired enlisted men and women of the U.S. Armed Forces. In listening to you today, my mail reads just exactly like your mail. Our members are expressing increased concern and an outrage over the high cost of the supplemental premium provision of the Act itself.

This Act requires older Americans to pay for the increased medical benefits because they are the ones that use them. As we all know, there are a variety of ways to pay for anything. The members of the Retired Enlisted Association have paid with over 1 million years of collective service to our great nation in the U.S. Armed Services. Our members served during World War II, the Berlin Airlift, Korea, the Straights of Formosa, Lebanon, Cuba, Vietnam, Grenada, the Persian Gulf and wherever else America chose to show the torch of freedom.

As a direct result of those many years of faithful and honorable service, military retirees and their eligible beneficiaries have earned the benefits of medical care as provided by military treatment facilities. The military retiree, by virtue of being a veteran, is also eligible to receive medical care provided by the Department of Veterans Affairs Health Care System. Congress has provided those benefits under Title 10 and Title 38, U.S. Code, and for those benefits we are most deeply grateful.

It does seem ironic to my members, however, when they reach the age of 65 they are told that you will participate in Medicare. At the same time, they are still eligible, they do not lose the benefits of the military treatment facility system, they are not told you are no longer a veteran, you cannot go into the VA medical care system. This is also the time that their income is reduced the greatest amount.

I would like to tell you a little bit about our members. According to the fiscal year 1988, the Department of Defense Statistical Report on the Military Retirement System, the largest group of military retirees have retired at the enlisted pay grade of E-7; their average net salary is $856 a month. By the way, the next largest group is enlisted pay grade E-6; and they receive a little less than $856 a month.

This year a retired E-7, filing jointly, can expect to have to budget an unanticipated $18.75 each month to pay for the Medicare surtax. By 1993 it is anticipated that this same couple will have to budget $35 a month. This does not address the fact that there is no statutory limit on the maximum surtax a beneficiary will have to pay.

We heard testimony today talk about the little guys, you know good and well, the people with smaller incomes, will not have to pay a lot. One of things I do—I am a National Service Officer, accredited by the Department of Veterans Affairs now, and I have worked a lot helping widows of deceased veterans and older veterans; and $25, $30 a month is a heck of a lot of money when you are on a fixed income.

We believe there are many—getting back to the subject, there are many positive provisions with the Act that may benefit some beneficiaries. It is sincerely hoped that you can appreciate the severe negative impact that the surtax provision will have on the quality of life of retired enlisted men and women over the age of 65, now and in the future.

The Retired and Enlisted Association respectfully urges you to support S. 335 introduced by Senator McCain which, in part, would delay for a year the implementation of the supplemental premium surtax and afford the entire Congress the opportunity to determine whether it ought to restructure the Act to deal with the concerns of our nation's senior citizens.

As we all know, the first penny of the surtax that goes in the Treasury, it is like dropping an anchor in concrete.

Mr. Chairman, members of the Committee, we thank you for allowing us to participate in the democratic process as you have so graciously done today.

Thank you.

[The prepared statement of Mr. Adams appears in the appendix.]

The CHAIRMAN. I would like to now defer to the distinguished Senator of Nevada, Senator Bryan, for such comments as he might like to make as to the next witness.

STATEMENT OF HON. RICHARD H. BRYAN, A U.S. SENATOR FROM NEVADA

Senator BRYAN. Mr. Chairman, I would like to thank you for calling this hearing today. It is my pleasure to introduce to you and the other distinguished members of the committee, Mr. Dan Hawley of Las Vegas.

Again, I very much appreciate your consideration of the Medicare Catastrophic Coverage Act of 1988, and I hope that this issue will be properly revisited.

I thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Hawley.

STATEMENT OF DANIEL L. HAWLEY, PRESIDENT, SENIORS COALITION AGAINST CATASTROPHIC ACT, LAS VEGAS, NV

Mr. HAWLEY. Thank you, Senator Bentsen, members of the Committee. I am Daniel L. Hawley, President of the Seniors Coalition Against the Catastrophic Act.

Before you are six large boxes containing the mandate of 346,427 registered voters from throughout the United States in SCACA's national petition to demand repeal of the Medicare Catastrophic Act. These are grass roots Americans who are angry with the Act which is ill conceived, politically pushed and heavily lobbied by AARP. These 346,427 signatures are not rich seniors belly-aching about paying a newly conceived method of taxation. They are the low and middle-income Americans who know they are going to pay for this boondoggle.

The congressional fire insurance similarly is not valid because in this mandatory policy only 7 percent can benefit under Part B and only 16.8 will receive benefits under the prescription drug section. The seniors are also aware that the premiums are ever increasing. The ACFA internal document brings forth one of the most controversial issues in this Act—the drug benefit portion of the Act which the seniors never asked for, but what they must, if AARP was to give their blessing to the Act is in deep financial trouble.

HCFA actuaries now predict the deficit and the drug insurance trust fund in 1991 of almost $500 million. By the end of 1993 the drug trust fund deficit is estimated to reach $4.5 billion. Already HCFA is proposing increases in the premiums, co-insurance and deductibles. Is it Congress's intention to continue to barge ahead regardless of the consequences?

The grass roots became completely enraged when the random telephone survey of AARP was publicized. They knew that it was slanted and they wanted a survey of their own. In response, SCACA circulated an 11-question survey through the seniors newspapers—7,921 have been returned—86 percent of the respondents are 65 years of age or older and the oldest is in his nineties.

Since Congress was lobbied right up to the moment of voting on this Act by AARP, saying that the seniors wanted this Act, questions 9 and 10 were included. Seventy-nine percent (79%) stated that they are members of AARP, but 91 percent said that AARP does not—I repeat, does not—represent their opinion in AARP's support for this Act. Only 407 of 7,921 said that AARP spoke for them. Thus, our survey shows that AARP only speaks for 5 percent of America's seniors on this Act.

Gentlemen, listen to the voice of the people, not the highly paid staff and hired lobbyists who are out to protect their own jobs and could care less about the welfare of the seniors. Seventy-eight percent (78%) of the seniors say that they understand the Act, yet 90 percent said that the benefits of the Act are not worth the increases in the premiums, nor the cost of a new method of taxation. Eighty-nine percent (89%) believe that the new radically conceived supplemental premium is unconstitutional.

Senior power are two words that Congress is going to hear over and over again. These two words translate into one important word—votes. Unless the Medicare Catastrophic Coverage Act is repealed SCACA forecasts the greatest turnover in the history of Congress, beginning with the 1990 election. Individually Congress may have millions of dollars of PAC money to run their reelection campaigns, but the seniors have their individual votes and money cannot buy them.

There is historical precedent for repeal; and I think that many members of Congress enjoy the benefits of the repeal of prohibition. Repeal is simply the recognition by Congress that the will of people is being acknowledged. Set the example of a true democracy for the rest of the world. President Bush must practice what he preached to Mr. Noreiga. I quote, "Respect the voice of the people."

I will close my testimony by asking you two questions, Senator Bentsen. Will you please answer the question most often asked by the seniors—Is the supplemental premium a tax?

The CHAIRMAN. Go ahead, Mr. Hawley.

Mr. HAWLEY. And if it is not a tax, by what authority does the IRS have the right to assess, collect and enforce an insurance premium? And is Congress willing to allow the IRS to confiscate property and jail seniors who cannot pay their supplemental premium?

Number two—Will you, Senator Bentsen, sign a letter stating that the definition of income contained in tables 1 and 2 prepared by the Joint Committee on Taxation, dated June 9, 1988, which includes untaxed income from seven additional sources, will never be used to compute the supplemental premium or the Medicare Catastrophic Act, nor any other health care plan?

I thank you, gentlemen, for your valuable time. I know that you are busy people. I ask you to please read the testimony that I have submitted to the Committee and the Appendices submitted by SCACA. They are the voices of the grass roots of America asking you to repeal the Medicare Catastrophic Coverage Act.

[The prepared statement of Mr. Hawley appears in the appendix.]

The CHAIRMAN. Thank you, gentlemen.

Now we hear a lot of grass roots and that is part of our job, and that is why you have been allowed to testify and been invited to testify—each of you. And we have heard from many interest groups, as we should—that is the way a democracy operates. Whether we are talking about AARP or we are talking about the National Council of Senior Citizens, we are talking about the United Auto Workers or we are talking about you gentlemen, and the groups that you represent. That is the job we were hired out to do.

When you talk about military people, I happen to have been one. I put in my time in defending my country. So I understand where you are coming from in regard to that. We have tried to do the very best we could after listening to all of those various interest groups. I happen to think we have done a good job and that the catastrophic illness piece of legislation is a good piece of legislation.

We have put in many safeguards in it. When we talk about the kind of Medigap policies—and I used to be in the business—that are available today, and we look at loss ratios and what they pay, as compared to what we pay under Medicare and what we will pay under catastrophic illness, there is an enormous difference. When we look at the situation, insofar as the kind of coverage in general that is there, there is a substantial amount of excess coverage as compared to most Medigap policies that we have in this particular piece of legislation.

To say that we will not review it—of course we will review it. I have reviewed every major piece of legislation that I have been a part of, and that is what we should do, that is a part of our responsibility and that is what we are doing with these hearings, and that is why we are listening to people as we have today.

That is why we have the general accounting office in. It has done an extensive review of Medigap policies to try to see what kind of benefits that they are providing and at what cost to senior citizens today who often are not in a position to fully evaluate that policy.

When I listened to Senator Durenberger, one of the most knowledgeable men I know in this business, talk about the problems of deciphering all of these policies and telling his mother what is really covered in those policies, I know what we are all up against. That is why we put out information—once a year now—on the catastrophic, telling people what is covered and what is not covered in trying to have them better informed to arrive at their decisions. That is what we are trying to achieve.

Do they want long-term care? Of course they want long-term care. Is that probably the number one? It probably is. I also understand the costs that are involved in that. I look at $5–6 billion for the cost of this one and see that the controversy that we have had in trying to follow through, with the dictates of President Reagan and how it should be paid for; and we approved that. We went along with it—the controversy resulting from that.

Then I look at the cheapest—the least expensive—of the long-term care that I have seen proposed to us and it is over $30 billion. And in a time of budget crunch, how do we handle it? How do we put it in there? Do I want to do it? Would I like to it? Sure, if I can figure out how we can do it without too much of a tax burden on the people of America and that we try to get the deficit down at the same time.

Those are the concerns that we are addressing and those are the things that we are trying to work for.

Now when you try to tell me that catastrophic illness is not worth that cost, I do not believe that. I think it is. And that is because of all the studies that we have made. This was not passed in the middle of the night, in the dark of the night. It was not slipped through. This was done over 2 years. I started hearings on these in 1984 in the Joint Economic Committee because of my deep concern with this issue, trying to address the concerns of Americans who could see their life savings wiped out—wiped out—that of the wife and that of the kids sometimes coming in to try to help.

Have I seen some of those kinds of costs? Do I personally understand them? You bet I do. That is what we have been working for. It is the sincere, conscientious effort, Mr. Hawley, on the part of every member of this Committee—trying to do what he thinks is right for America. That is what we have done.

Now, gentlemen, let me review for a moment. The way the catastrophic insurance legislation addressed the concerns of retired Federal employees. First, the legislation provided for a special credit against the amount of the supplemental premium to assure that Federal retirees, whose annuities are taxable, pay the same premium as individuals receiving Social Security benefits. This credit was designed to treat Federal retirees equitably.

Second, the legislation provided for a premium rebate under the Federal Employee Health Benefits Program, so that Federal retirees would not have to pay twice for any duplicate benefits provided under FEHBP and Medicare. As I understand it, General Accounting recently concluded that the premium rebate granted by OPM of $3.10 monthly is a reasonable amount of the value of duplicate benefits.

Now, third, the legislation called for OPM to study further reforms in FEHBP. They could help address any duplication of benefits, such as the possibility of offering Medigap supplemental policies to Federal retirees.

Now, in each of these cases, it is my understanding, that Federal retiree groups worked with the Congress to address the concerns of Federal retirees, but now you seem to have many objections to the legislation. And I want to know, from what I have been told, why your position has changed.

Mr. Morrissey.

Mr. MORRISSEY. Mr. Chairman, our position has not changed; our position is that we are faced with a new tax to pay for something we already have under the Federal Employee's Benefit Program.

I recognize the fact that with the help, working with the Congress and the Senate, we were able to get two amendments into what became the final Act. Those were benefits to make it fair and equitable, as you have pointed out, with Social Security on the first premium. The hue and cry I am receiving, as all of the members of the Senate and the Congress are, is this new surtax for something that they already have, they are already paying for and they do not need. I am also understanding from other seniors they are crying the same thing.

So our position has not changed, Mr. Chairman.

The CHAIRMAN. Well, it is my understanding that the majority of Federal employee annuitants do, in fact, earn Medicare coverage through their own or a spouse's Social Security covered employment—the majority of them do. And further, because Medicare is the primary payor for individuals eligible for both Medicare and Federal employees health benefits, that the largest share of an individual's bills will be paid by Medicare.

Now is that correct? And let me say, can you tell me then, if it is correct, what the rationale would be for not charging Federal retirees for those benefits.

Mr. MORRISSEY. First of all, you are correct that the majority of the Federal retirees also qualify, just like anybody else in this country, for Social Security benefits, including coverage under Medicare A and those that do not qualify, many of those go on and purchase Medicare B. My wife is a good example of that.

Again, Mr. Chairman, we are not arguing that part of the law. We are not arguing the cost for that part of the law. We are arguing an additional tax for benefits we already have and are paying for and we get nothing in return, other than what we already have and are paying for.

The CHAIRMAN. I have used more than my time and I apologize. Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, thank you very much.

Let me begin by expressing my appreciation to you for taking at least 5 minutes or more so I could collect my thoughts.

I sat here this morning—you do not know this, Mr. Chairman, but sitting down there in the well while we were here this morning was my 22-year-old son and sitting behind a camera. I knew that when I got to the end of this day, at whatever time it would be, I would be looking at four people my age or older, who would come in here and they would talk to us about how they represent low and middle-income America; how little people can do on $30 a month, they would have a poll; they would have six boxes or something of petitions; they would tell us about having to listen to the voice of the people and then one would end up threatening us at election time.

I was sort of wondering to myself as I looked at this kid, who cannot afford health insurance, unless I buy it for him—even if he was a Federal employee, he would be paying—well, you know what the rates are, even with a big supplement. You and I have priced him out of housing. We had to have those homes that were nothing down, forever to pay all of the interest and everything else deductible and that kid is not going to pay a house in the next 10 years. He cannot work his way through college like you and I did back in the old days.

When I spent the 2 years, or the 3 years, that the Chairman referred to trying to do catastrophic the right way for his grandmother and his grandfather, it was not easy, as the Chairman has indicated. It is not easy. And it is particularly not easy knowing that at some point somebody is going to come in here with his poll, and his boxes, and his petitions, and his grass roots, and his $30 a month payment and all that sort of thing and then threaten us at the polls.

But I have the comforting feeling of knowing, not only how much I care about that kid, but a lot of other people that this so-called widespread grass roots stuff is coming from a bunch of folks my age and a little bit older. It is not coming from my parents in their eighties. It is not coming from him. And I do not want to turn this into some sort of a dumping on my generation. Please, I am not doing that.

I am trying to pick up on something the Chairman said, which is that maybe instead of spending our time putting out this kind of trash, like condemning AARP—this that I am holding up here is the Seniors Coalition Against the Medicare Coverage Act thing—that spending his time dumping on AARP and he is representing at least 346,000 people like my mother and dad that this bill does not address nor cover most catastrophic care costs. It was fraudulently represented to senior citizens. It reduced actual coverage and benefits to senior citizens. It has not addressed the noncoverage and gaps in Medicare. It means that senior citizens are and will fund in the future most of the medical costs of AIDS patients.

I mean, this is not what we worked on, Mr. Chairman, for 2 years. It is not the same bill. But I think what I heard you say to all of these people and the people that they represent, that their being here as value because we do need to hear from these people.

But probably one of the things they can do best to help us is to deal with some of the other related issues around affordable health care because we have to make health care affordable for all Americans. There are too many that cannot have what we can have. There are too many who do not have the $30 a month or whatever it takes. And we are wasting a lot of money today in a lot of areas. We talked about Medigap today and other things like that.

And so, I would hope that the same energy that your testimony today, gentlemen, indicates is going to be spent on trying to change this bill and getting behind Senator so and so, and Senator such and such. That is fine. I think that is part of the system and the way it works.

But I would hope and I would pray that the same amount of energy on behalf of all of those people would be put into looking at a lot of the other things in the system that caused these health care costs to be out of sight. Because we can talk all we want about this is not the way a social insurance system should work and we should not be required to pay more, or this or that and the other thing. But the reality is that the cost of getting into the system today—and I am just holding up the Federal Employee Health Benefit Plan—is out of hand. It is out of control.

And so what we are looking for on this Committee is the best ideas we can find from everybody, I guess. And the Chairman is the most open person around here. He was holding catastrophic hearings in 1979 when I got here, not in 1984, in 1979. So I think we are as open as anybody you are going to find around this place, but we do need a wider variety of help, I suppose, and we really, I think, for one—maybe it is because I have 6 years to go or something—I think we are beyond the threat stage.

I think right now those of us who are trying to think of ways to get affordable health care more affordable for all Americans, not just for certain Americans, I think this widespread support in America is with us. If you want to prove differently, Mr. Hawley, go ahead and try. But I am going to get a lot of folks like that kid sitting there to come on in and talk to you about this same problem.

Mr. HAWLEY. May I answer you for just a second, sir?

The CHAIRMAN. Yes, of course.

Mr. HAWLEY. Thank you, sir.

Included in my written testimony is a plan for an American health care plan which we have submitted to you, which calls for four sectors of the United States to work together for the betterment of all Americans. It would be less than honest to say to you that it will be a very ticklish proposition to get the four sectors together to accomplish this. But until we come up with the idea of what is in it for American and not what is in it for ourselves, I think that we will never have an American health care plan.

The insurance industry must come up with a policy that is equity for all of the Americans. The beneficiaries, which would be all of America, must recognize that they must pay their fair share of such coverage.

The medical care providers, which are the cause of the 16 percent increase per year in medical costs, when the people on Social Security only get 3 to 4 percent cost of living raises. The two do not add up. And until we put cost controls on the medical providers, we will never be able to have a health care plan.

The fourth sector, which is prime importance, and I know you gentlemen have diligently as hard as you can, to provide what you believe is the most important thing for seniors today. But the health care plan must be taken off that tomorrow burner and put on the today burner. That is one of the reasons that SCACA has asked that a Presidential Commission be appointed to look at the health care issues of the United States. We offer our services to be able to look at that.

I am not saying it is compulsory.

The CHAIRMAN. Mr. Hawley, that is fine. I just do not put up with threats and that is what you were doing and I resented it deeply. You do not understand me very well when you come up that way.

Yes, Mr. Morrissey.

Mr. MORRISSEY. Mr. Chairman, may I make a remark?

The CHAIRMAN. Yes.

Mr. MORRISSEY. Speaking on behalf of the Association I represent, and as a member of the recently established coalition, it has never been our intent to come before this body or any single member of the Senate or the Congress and threat.

The CHAIRMAN. I know that, Mr. Morrissey.

Mr. MORRISSEY. Well, I am at this panel table and when conversation to that extent is directed at this panel——

The CHAIRMAN. It is directed at the gentleman who gave the threats.

Mr. MORRISSEY. Thank you, sir.

The CHAIRMAN. And that gentleman does not know me very well. All right, are there any other comments here?

Senator ROTH. Mr. Chairman, I do have an opening statement which I would like to have entered.

The CHAIRMAN. Fine. We will be happy to have it.

Senator ROTH. I would like to make just a few comments. As the Chairman well knows, even though on this matter I come from a different direction. I have always been impressed with the sincerity and objectivity of the members on both sides of this Committee. There is no question in my mind that the Committee members sought to do what they thought was right. And as is usual some members had a difference of opinion.

I might say, gentlemen, I am one of the few who voted twice against the legislation and I would have to say to you that in my State of Delaware, the senior citizens made it clear to me that they did not think catastrophic insurance was in their interest. They made their views known to me prior to the first Catastrophic Insurance vote on the Senate floor. So in my case I was fortunate that Delaware senior citizens studied the legislation and very persuasively convinced me to vote against the Medicare changes.

Last Congress I voted against Catastrophic, and this Congress I co-sponsored legislation to delay its implementation. But I have also introduced—and I would like to get your comment on this—another proposal which would repeal all new Medicare benefits and new premiums due after December 31, 1989. The sections to be repealed would include the Medicare Part B benefits, as well as the annual supplemental premium. But Medicare beneficiaries would continue to enjoy the additional benefits already in effect, including the extended hospital coverage, the 150 days of skilled nursing home care, unlimited hospice care, and the spousal impoverishment protection.

Seniors would continue to pay the catastrophic premiums, which is currently $4 and would go up to $6.73 in 1993. But as I say, would not be charged the supplemental fee.

I wonder if any of you gentlemen would care to comment on that proposal. In other words, keep the current expanded benefits in effect but cancel both new benefits and premiums in the future as an alternative to the bull you endorsed—which would not cancel but delay for a year. Would any of you care to comment on this proposal?

Admiral KILCLINE. Yes, Senator, I would like to comment. The general proposal is a good proposal, whether we defer or repeal the second phase and third phase, is the difference. I think that one of the things that we looked at in our survey was what is most important in the catastrophic cap legislation. Most of the items that are looked upon in the most friendly way are items that are already in phase one, Part A. I do not think there is any way that we would want to disrupt that.

Whether we defer—I prefer thinking about deferring Part B and Part C as I call them—the second and third phase—and let us consider the whole package rather than repeal it completely. If you start repealing, you start losing some understanding, some appreciation of the total value of the bill. The approach is a good approach. But the real complaint that most people have is really the funding mechanism and you need to take a look at the whole package—how can we fund the second and third phase with a different system other than a surtax.

That is pretty much the principal thrust. To redesign, to try to include long-term care is beyond the scope of this kind of a bill. I do not think that is what people are looking for right now. They want that kind of help, but that is not what they are complaining about. They are looking for something that will hold what we have and let us take a hard look at the surtax. Can we be serious about a different way to pay for the act?

Mr. MORRISSEY. Senator Roth, I would echo what my colleague has said. I would also point out that our Association stands ready to work with anybody that is going to make this more acceptable to all people of this country. And certainly what you have projected here—we have already gone on record supporting that proposed legislation that Senator McCain—and much of what you say is in the same ball park.

Senator ROTH. Any further comment?

[No response.]

Senator ROTH. All right. I would be appreciative of any written comments you may care to make at a later time.

That is all I have, Mr. Chairman.

The CHAIRMAN. All right. Thank you very much, gentlemen.

[Whereupon, the hearing was adjourned at 5:28 p.m.]

APPENDIX

ALPHABETICAL LISTING AND MATERIAL SUBMITTED

PREPARED STATEMENT OF JOHN M. ADAMS

Mr. Chairman and distinguished members of the committee, The Retired Enlisted Association [TREA] is sincerely grateful to the committee for scheduling this hearing to exclusively hear testimony on the catastrophic health care issue.

The Retired Enlisted Association is proud to represent enlisted men and women retired from the U.S. Armed Forces for length of service or those members uho are permanently medically retired.

Today you have heard from witnesses offering a variety of information for your consideration. The Retired Enlisted Association is proud to have been one of the sponsors of the survey described by Admiral Kilcline of The Retired Officers Association. As you and members of your staff will note, the survey was unbiased and not self serving per se. If I may, I would like to be a bit parochial in my testimony on behalf of retired enlisted men and women of the U.S. Armed Forces.

Our members are expressing increased concern and outrage over the high cost of the Supplemental Premium provision of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360).

This Act requires older Americans to pay for the increased Medicare benefits because, "they are the ones who use them."

As we all know, there are a variety of ways to pay for anything. The members of The Retired Enlisted Association have paid with over 1,000,000 years of collective service to our great Nation in the U.S. Armed Forces. Our members served during WW II, the Berlin Airlift, Korea, the straits of Formosa, Lebanon, Cuba, Vietnam, Grenada, the Persian Gulf and wherever else America chose to show the torch of freedom.

As a direct result of those many years of faithful and honorable service, military retirees and their eligible beneficiaries have earned the benefits of medical care as provided by Military Treatment Facilities. The military retiree, by virtue of being a veteran, is also eligible to receive medical care provided by the Department of Veterans Affairs Health Care System.

For those benefits, we are most grateful. It does seem ironic to our members though, that when they reach the age of 65 they are forced to participate under Medicare, yet they are still eligible to receive medical care at the Military Treatment Facilities and Department of Veterans Affairs Medical Centers.

According to Fiscal Year 1988, the Department of Defense statistical Report on the Military Retirement System, the largest group of military retirees have retired at the Enlisted pay grade of E-7. Their average net salary is $856 per month. This calendar year, a retired E-7 filing jointly can expect to have to budget an unanticipated $18.75 each month to pay for the Medicare surtax. By 1993 it is anticipated this same couple will have to budget $35 a month. This does not even address the fact that there is no statutory limit on the maximum surtax a "beneficiary" will have to pay.

Though there are positive provisions within the Act that may benefit some beneficiaries, it is sincerely hoped that you can appreciate the severe negative impact the surtax provision will have on the quality of life of retired enlisted men and women over the age of 65 now and in the future.

The Retired Enlisted Association very respectfully urges you to support S. 335 introduced by Senator McCain which in part, would delay for a year implementation of the supplemental premium (surtax) and afford Congress the opportunity to determine whether it ought to re-structure the Act to deal with the concerns of our Nation's senior citizens.

Mr. Chairman, members of the committee, we thank you for allowing us to participate in the democratic process as you have so graciously done today.

PREPARED STATEMENT OF SENATOR DAVID L. BOREN

Mr. Chairman, I am very appreciative to you for your decision to hold this hearing on an issue that is of great concern to all of us. It is obvious the interest that surrounds the issue by the attendance present today.

After almost two years of work, Congress last year passed the Medicare Catastrophic Coverage Act, marking the largest expansion of the Medicare program since it began. Former Secretary of Health and Human Services Otis Bowen was very instrumental in the development and passage of this legislation. Over 32 million Medicare beneficiaries are protected by this extended coverage, which caps the amount persons are required to pay for hospital care, physician expenses, prescription drugs, skilled nursing home care, and a number of other health care costs as well.

This legislation will extend important new protection to thousands of Oklahomans who could otherwise be financially devastated by the cost of a major illness. We still need to address the problem of long-term care, but this measure is certainly a beginning in helping our elderly pay for catastrophic health care costs.

However, while we need a way to protect against the devastation caused by catastrophic illness, it is also clear there are problems with the way this current program is being financed. I have supported efforts in Congress this year to find ways to lessen the burden of financing the program. Congress should reduce federal catastrophic health insurance premiums if recent Congressional Budget Office reports are accurate that current collections greatly exceed what is necessary to run the program. The initial report indicated that the new law could produce almost $5 billion more in revenue than necessary to pay for the new benefits over the next five years. If this surplus means we can reduce premiums, we should move quickly to do so.

We must use every opportunity to try to reduce the burdens placed on the elderly. Senior citizens have come to rely greatly on both Medicare and Medicaid, and because they often live on small, fixed incomes, they are especially susceptible to inflationary and economic pressures. We must ensure that our system of health care insurance to the elderly sufficiently meets their growing needs.

Again, Mr. Chairman, thank you for all of your work on this issue. I appreciate your efforts in developing the legislation and in educating the public of its benefits. I am hopeful that the financing mechanism can be adjusted to make this program more acceptable to those who will pay for it and benefit from it. Thank you.

PREPARED STATEMENT OF LOVOLA BURGESS

Thank you, Mr. Chairman. My name is Lovola Burgess, from Albuguergue, New Mexico. I am Vice President of the American Association of Retired Persons. AARP appreciates this opportunity to present its views on the Medicare Catastrophic coverage Act, particularly on the issue of excess revenues now being projected for the two catastrophic trust funds.

Before addressing this issue, I want to thank you, Mr. Chairman, your colleagues, Chairmen Rostenkowski and Dingell in the House, and President Bush for your continued commitment to the full implementation of this Act. As this committee knows, AARP did not like the financing requirements that were imposed—specifically that aspect which requires beneficiaries to pay the entire cost of the Medicare improvements—but, like you we believe that the benefits in the Act are of such importance that they warranted and continue to warrant AARP's support. As our Board stated in March of this year, we remain open to new proposals for funding and "will evaluate them in light of their equity and potential for support."

In all the controversy over the Act's financing, it is easy to lose sight of the benefits. When fully implemented, the benefits under the Act will assist almost one in four beneficiaries each year. And over one's lifetime, 75-85 percent of Medicare's beneficiaries will receive help from the benefits in the Act.

This year alone:

- 1.1 million beneficiaries will be aided by the reduction in the number of hospital deductibles for which they are liable.

- 160,000 will benefit from the elimination of coinsurance liability beyond the 60th day of a hospital stay; others will benefit from the expansion of skilled nursing facility care.
- 2.7 million should—and here we need the Committee's help to make sure that states follow through—benefit from the Medicaid "buy in" to Medicare.
- And when the spousal impoverishment benefit begins on September 30 of this year, 110,000 couples (or over 200,000 beneficiaries) will be protected against spousal impoverishment each year.

I know how important these new benefits are in my own family's life. For example, my 97-year old mother-in-law has a history of broken bones. She has already been in the hospital twice this year, but under the catastrophic legislation she has paid only one deductible. If her pattern continues, she could be hospitalized several more times this year.

The mother of a close friend of mine was hospitalized for weeks this year. She eventually died in the hospital. My friend tells me she believes her father would have been devastated financially but for the catastrophic legislation.

In 1990 and beyond, 2.3 million beneficiaries will benefit each year from the limit on doctor bills; and 5.5 million will benefit from the limit on prescription drug costs; another 300,000 will be aided by the respite benefit, and so on, for home health, mammography, and hospice.

I'd like to turn now to the issue at hand. This committee has asked us to comment on what should be done about the excess revenue now projected from the supplemental premium. AARP offers the following recommendations:

First, we need to know why and how the revenue estimates changed. Is the change due to new data; a one time capital gains increase; is it due to Tax Reform; is it new analysts, or techniques; is it a one-time phenomenon? The caution expressed by the President and others should not be dismissed out of hand.

Our concern in this regard is not simply an academic interest. Many members of this committee as well as your counterparts in the House invested a substantial amount of time and effort trying to perfect both the benefits AND the financing. Likewise many members of this committee, as well as the Senate and House at large—and AARP—have borne the burden of criticism and controversy surrounding the financing. It is vital that this committee get some answers, and understand thoroughly the reasons for these new estimates, lest a decrease in the supplemental premium this year be followed by a needed increase a year or two in the future.

Second, if the excess reported by the Chairman can be corroborated, and a solution developed that responds to the excess, it is imperative that this effort not lead to tampering with the benefits. AARP is opposed to any delay or repeal of the benefits in this important Act. Even those most critical of the Act's financing support its benefits.

Third, AARP has reviewed a number of possible options, prompted by the Chairman's statement of April 20. In broad terms, they are as follows:

> Do Nothing: Both the President and Secretary Brady have expressed concern—not without some justification—that the estimates of program costs, particularly with respect to the prescription drug program, may be higher than estimated. Indeed this Administration continues to hold the view of the previous Administration that the prescription drug benefit will cost more than anticipated. (It should be noted, however, that the Administration's latest estimates are lower than their previous estimates in this area). AARP believes that the prescription drug program warrants careful oversight—that it cannot be put on "automatic pilot". However, the Act includes a number of safeguards as well as a Commission on drug costs, which are designed to monitor costs and keep costs in line. Moreover, to set aside yet another $4 billion in addition to the contingency which is established in current law seems to us to invite the pharmaceutical industry to run-up costs.
>
> Reduce the Supplemental Premium Cap: The cap on the supplemental premium is currently set at $800 per beneficiary in 1989 ($1600 for a couple) and rises to $1050 in 1993. Assuming that the excess revenues are on the order of $4.3 billion over the five year period (1989-93) the maximum supplemental could be reduced to $500 in 1989, $550 in 1990, $600 in 1991, $700 in 1992, and $800 in 1993. This option would affect primarily the singles above $35,000 and couples (both in Medicare) above $50,000 or roughly the top 10 percent of beneficiaries.
>
> While clearly attractive to those at or near the cap, this option benefits the smallest number of people and has the effect of making the supplemental premium—and indeed the financing of the catastrophic program generally—more regressive.

Increase the threshold on the supplemental: Under current law, a Medicare (Part A) beneficiary starts paying the supplemental at the point that he or she has $150 or more in federal income tax liability. Increasing the threshold on the supplemental would raise the tax liability level at which the supplemental premium is imposed. This option would provide relief to those at the low end of the supplemental, but ignore the broader middle income group. It would also narrow the proportion of Medicare beneficiaries paying the larger portion of program costs via the supplemental, now at roughly 40 percent.

Reduce the supplemental premium rate: Under current law, the supplemental premium is assessed at $22.50 per $150 of federal income tax liability in 1989, or 15 percent. This rate increases each year reaching $42.00 per $150 of tax liability in 1993, or 28 percent.

Our estimates show that if the excess revenues, estimated to be around $4.3 billion over five years, were applied to the rate, it would be reduced as follows:

	Current law (percent)	Revised (percent)
1989	15	10.5
1990	25	17.5
1991	26	18.2
1992	27	18.9
1993	28	19.6

This option affects the largest number of beneficiaries, on an equal percentage basis, from those paying the least, to those paying the most. It maintains the progressivity under the current approach, and while it does not reduce the number of supplemental premium payers, it does slightly reduce the number paying the maximum. Accordingly, AARP recommends that any excess of revenue from the supplemental premium be used to reduce the supplemental premium rate.

The following table indicates the likely change in supplemental premiums that would follow from such a change. Appended to this testimony are more comprehensive case studies which examine the impact on beneficiaries of this reduction in the rate for the years 1989, 1990 and 1993.

	Single Payer/1990			Couple (Joint) Payer/1990		
Total Income	$20,000	$30,000	$40,000	$30,000	$40,000	$50,000
Current Law	225	563	850	225	563	1,013
Reduced Rate	158	395	850	158	395	710

Finally, Mr. Chairman, even as we attempt to grapple with the immediate issue, we must not lose sight of the larger problem of health care costs—which affects all Americans—and the problems of access to acute care for some 37 million of our fellow citizens and the need for long-term care. It would be easy to attribute the controversy over the financing of catastrophic to only the particulars of this Act. But we know that this is not the case. In study after study, poll after poll, Americans of all ages express concern, bordering on alarm, at the increases in their health care costs. Employers too have indicated their concerns, as they watch—despite efforts in some quarters—their health benefit costs rise almost uncontrollably. AARP believes that the time has come to turn our attention to these needs, for they are at the root of many of our current discomforts.

Thank you Mr. Chairman.

Enclosure.

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AARP Board's statement on new catastrophic law

The AARP Board of Directors concentrated heavily on health care financing issues at its meeting in mid-March. The following statement was issued:

The AARP Board has heard and shares the concerns of members with the rising costs of health care, particularly with respect to the method of payment for the Medicare Catastrophic Health Program.

We continue to support the important benefits provided by this law, and therefore oppose repeal or delay in its implementation.

AARP did not propose the Act's financing method and does not believe it is the best approach.

We remain open to new proposals for funding the Catastrophic Program and will evaluate them in light of their equity and potential for support.

We remain committed to broad-based sources of financing for health care costs, along with stronger cost-containment and quality assurance measures.

We believe the best use of AARP's energies for the future continues to lie in advocacy for universal access to quality, affordable health care for all Americans for both acute and long-term care services.

Current Law
Married Enrollees, Two Age Exemptions, 1989

Total Income	Nontaxed Income	AGI	Itemized Deduction	Taxable Income	Income Tax	Supp. Premium	Total Premium	T. Prem./ Income (%)
$5,000	$5,000	$0	$0	$0	$0	$0	$96	1.9
10,000	8,500	1,500	0	0	0	0	96	1.0
15,000	11,000	4,000	0	0	0	0	96	0.6
20,000	11,500	8,500	0	0	0	0	96	0.5
25,000	11,500	13,500	6,000	3,100	465	68	164	0.7
30,000	12,000	18,000	7,000	7,000	1,050	158	254	0.8
35,000	12,000	23,000	7,500	11,500	1,725	248	344	1.0
40,000	10,000	30,000	7,500	18,500	2,775	405	501	1.3
45,000	9,000	36,000	8,000	24,000	3,600	540	636	1.4
50,000	9,000	41,000	8,500	28,500	4,275	630	726	1.5
75,000	8,000	67,000	10,000	53,000	10,917	1,600	1,696	2.3
100,000	7,000	93,000	12,500	76,500	17,482	1,600	1,696	1.7

Notes:

Nontaxed income is equal to excluded social security benefits.

Total premium includes $96 of basic premium.

Source: Price Waterhouse, May 31, 1989

Current Caps, 70.06 Percent of Current Rates
Married Enrollees, Two Age Exemptions, 1989

Total Income	Nontaxed Income	AGI	Itemized Deduction	Taxable Income	Income Tax	Supp. Premium	Total Premium	T. Prem./ Income (%)
$5,000	$5,000	$0	$0	$0	$0	$0	$96	1.9
10,000	8,500	1,500	0	0	0	0	96	1.0
15,000	11,000	4,000	0	0	0	0	96	0.6
20,000	11,500	8,500	0	0	0	0	96	0.5
25,000	11,500	13,500	6,000	3,100	465	47	164	0.7
30,000	12,000	18,000	7,000	7,000	1,050	111	254	0.8
35,000	12,000	23,000	7,500	11,500	1,725	174	344	1.0
40,000	10,000	30,000	7,500	18,500	2,775	284	501	1.3
45,000	9,000	36,000	8,000	24,000	3,600	379	636	1.4
50,000	9,000	41,000	8,500	28,500	4,275	442	726	1.5
75,000	8,000	67,000	10,000	53,000	10,917	1,138	1,696	2.3
100,000	7,000	93,000	12,500	76,500	17,482	1,600	1,696	1.7

Notes:

Nontaxed income is equal to excluded social security benefits.

Total premium includes $96 of basic premium.

Source: Price Waterhouse, May 31, 1989

Current Caps, 70.06 Percent of Current Rates Single Enrollees, 1989

Total Income	Nontaxed Income	AGI	Itemized Deduction	Taxable Income	Income Tax	Supp. Premium	Total Premium	T. Prem./ Income (%)
$5,000	$5,000	$0	$0	$0	$0	$0	$48	1.0
10,000	7,000	3,000	0	0	0	0	48	0.5
15,000	7,000	8,000	0	2,150	323	32	93	0.6
20,000	6,500	13,500	4,500	7,000	1,050	111	206	1.0
25,000	6,500	18,500	5,000	11,500	1,725	174	296	1.2
30,000	5,000	25,000	5,500	17,500	2,625	269	431	1.4
35,000	4,000	31,000	6,000	23,000	4,029	411	633	1.8
40,000	4,000	36,000	7,000	27,000	5,149	537	813	2.0
45,000	4,000	41,000	7,000	32,000	6,549	679	848	1.9
50,000	3,500	46,500	7,500	37,000	7,949	800	848	1.7
75,000	3,500	71,500	11,000	58,500	14,649	800	848	1.1
100,000	3,500	96,500	17,000	77,500	20,919	800	848	0.8

Notes:

Nontaxed income is equal to excluded social security benefits.
Total premium includes $48 of basic premium.

Source: Price Waterhouse, May 31, 1989

Current Law Single Enrollees, 1989

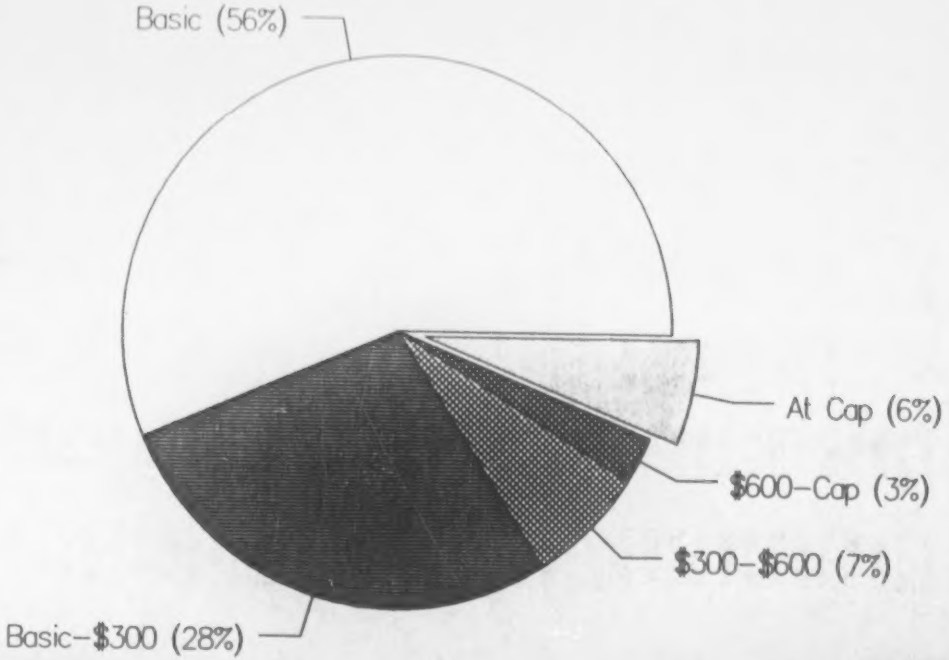
Total Income	Nontaxed Income	AGI	Itemized Deduction	Taxable Income	Income Tax	Supp. Premium	Total Premium	T. Prem./ Income (%)
$5,000	$5,000	$0	$0	$0	$0	$0	$48	1.0
10,000	7,000	3,000	0	0	0	0	48	0.5
15,000	7,000	8,000	0	2,150	323	45	93	0.6
20,000	6,500	13,500	4,500	7,000	1,050	158	206	1.0
25,000	6,500	18,500	5,000	11,500	1,725	248	296	1.2
30,000	5,000	25,000	5,500	17,500	2,625	383	431	1.4
35,000	4,000	31,000	6,000	23,000	4,029	585	633	1.8
40,000	4,000	36,000	7,000	27,000	5,149	765	813	2.0
45,000	4,000	41,000	7,000	32,000	6,549	800	848	1.9
50,000	3,500	46,500	7,500	37,000	7,949	800	848	1.7
75,000	3,500	71,500	11,000	58,500	14,649	800	848	1.1
100,000	3,500	96,500	17,000	77,500	20,919	800	848	0.8

Notes:

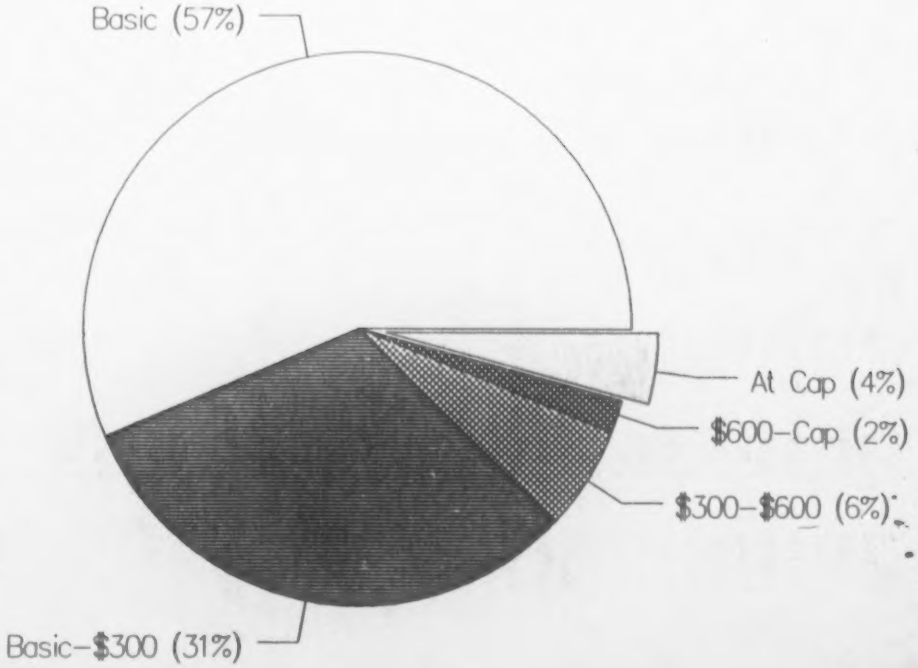
Nontaxed income is equal to excluded social security benefits.
Total premium includes $48 of basic premium.

Source: Price Waterhouse, May 31, 1989

Distribution of Enrollees by Premium Payment, Current Law 1989



Distribution of Enrollees by Premium Payment, Lower Rates 1989



Current Law
Single Enrollees, 1990

Total Income	Nontaxed Income	AGI	Itemized Deduction	Taxable Income	Income Tax	Supp. Premium	Total Premium	T. Prem./ Income (%)
$5,000	$5,000	$0	$0	$0	$0	$0	$59	1.2
10,000	7,000	3,000	0	0	0	0	59	0.6
15,000	7,500	7,500	0	1,400	210	38	96	0.6
20,000	7,000	13,000	4,500	6,450	968	225	284	1.4
25,000	7,000	18,000	5,000	10,950	1,643	375	434	1.7
30,000	6,500	23,500	5,500	15,950	2,393	563	621	2.1
35,000	4,500	30,500	6,000	22,450	3,758	850	909	2.6
40,000	4,000	36,000	7,000	26,950	5,018	850	909	2.3
45,000	4,000	41,000	7,000	31,950	6,418	850	909	2.0
50,000	4,000	46,000	7,500	36,450	7,678	850	909	1.8
75,000	4,000	71,000	11,000	57,950	14,243	850	909	1.2
100,000	4,000	96,000	17,000	76,950	20,513	850	909	0.9

Notes:

Nontaxed income is equal to excluded social security benefits.

Total premium includes $59 of basic premium.

Source: Price Waterhouse, January 23, 1989

Current Caps, 70.06 Percent of Current Rates
Single Enrollees, 1990

Total Income	Nontaxed Income	AGI	Itemized Deduction	Taxable Income	Income Tax	Supp. Premium	Total Premium	T. Prem./ Income (%)
$5,000	$5,000	$0	$0	$0	$0	$0	$59	1.2
10,000	7,000	3,000	0	0	0	0	59	0.6
15,000	7,500	7,500	0	1,400	210	26	85	0.6
20,000	7,000	13,000	4,500	6,450	968	158	217	1.1
25,000	7,000	18,000	5,000	10,950	1,643	263	322	1.3
30,000	6,500	23,500	5,500	15,950	2,393	395	453	1.5
35,000	4,500	30,500	6,000	22,450	3,758	658	716	2.0
40,000	4,000	36,000	7,000	26,950	5,018	850	909	2.3
45,000	4,000	41,000	7,000	31,950	6,418	850	909	2.0
50,000	4,000	46,000	7,500	36,450	7,678	850	909	1.8
75,000	4,000	71,000	11,000	57,950	14,243	850	909	1.2
100,000	4,000	96,000	17,000	76,950	20,513	850	909	0.9

Notes:

Nontaxed income is equal to excluded social security benefits.

Total premium includes $59 of basic premium.

Source: Price Waterhouse, May 2, 1989

Current Law
Married Enrollees, Two Age Exemptions, 1990

Total Income	Nontaxed Income	AGI	Itemized Deduction	Taxable Income	Income Tax	Supp. Premium	Total Premium	T. Prem./ Income (%)
$5,000	$5,000	$0	$0	$0	$0	$0	$118	2.4
10,000	8,000	2,000	0	0	0	0	118	1.2
15,000	11,000	4,000	0	0	0	0	118	0.8
20,000	12,500	7,500	0	0	0	0	118	0.6
25,000	12,500	12,500	6,000	1,650	248	38	155	0.6
30,000	12,500	17,500	7,000	6,400	960	225	343	1.1
35,000	13,000	22,000	7,500	10,400	1,560	375	493	1.4
40,000	13,000	27,000	7,500	15,400	2,310	563	680	1.7
45,000	10,000	35,000	8,000	22,900	3,435	825	943	2.1
50,000	10,000	40,000	8,500	27,400	4,110	1,013	1,130	2.3
75,000	10,000	65,000	10,000	50,900	10,034	1,700	1,818	2.4
100,000	10,000	90,000	12,500	73,400	16,334	1,700	1,818	1.8

Notes:

Nontaxed income is equal to excluded social security benefits.
Total premium includes $118 of basic premium.

Source: Price Waterhouse, January 23, 1989

Current Caps, 70.06 Percent of Current Rates
Married Enrollees, Two Age Exemptions, 1990

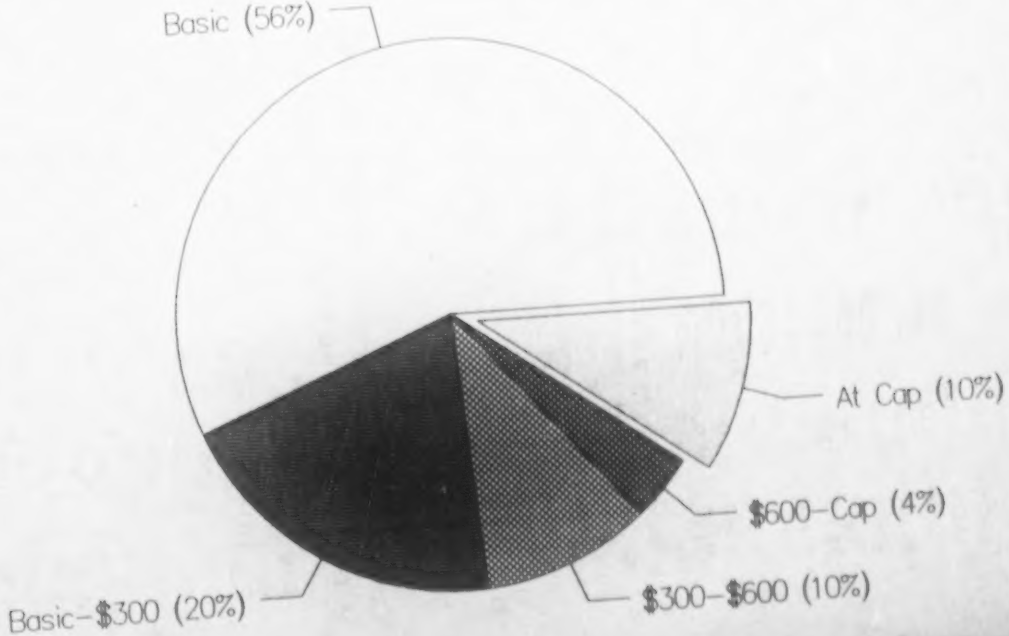
Total Income	Nontaxed Income	AGI	Itemized Deduction	Taxable Income	Income Tax	Supp. Premium	Total Premium	T. Prem./ Income (%)
$5,000	$5,000	$0	$0	$0	$0	$0	$118	2.4
10,000	8,000	2,000	0	0	0	0	118	1.2
15,000	11,000	4,000	0	0	0	0	118	0.8
20,000	12,500	7,500	0	0	0	0	118	0.6
25,000	12,500	12,500	6,000	1,650	248	26	144	0.6
30,000	12,500	17,500	7,000	6,400	960	158	275	0.9
35,000	13,000	22,000	7,500	10,400	1,560	263	381	1.1
40,000	13,000	27,000	7,500	15,400	2,310	395	512	1.3
45,000	10,000	35,000	8,000	22,900	3,435	579	696	1.5
50,000	10,000	40,000	8,500	27,400	4,110	710	828	1.7
75,000	10,000	65,000	10,000	50,900	10,034	1,700	1,818	2.4
100,000	10,000	90,000	12,500	73,400	16,334	1,700	1,818	1.8

Notes:

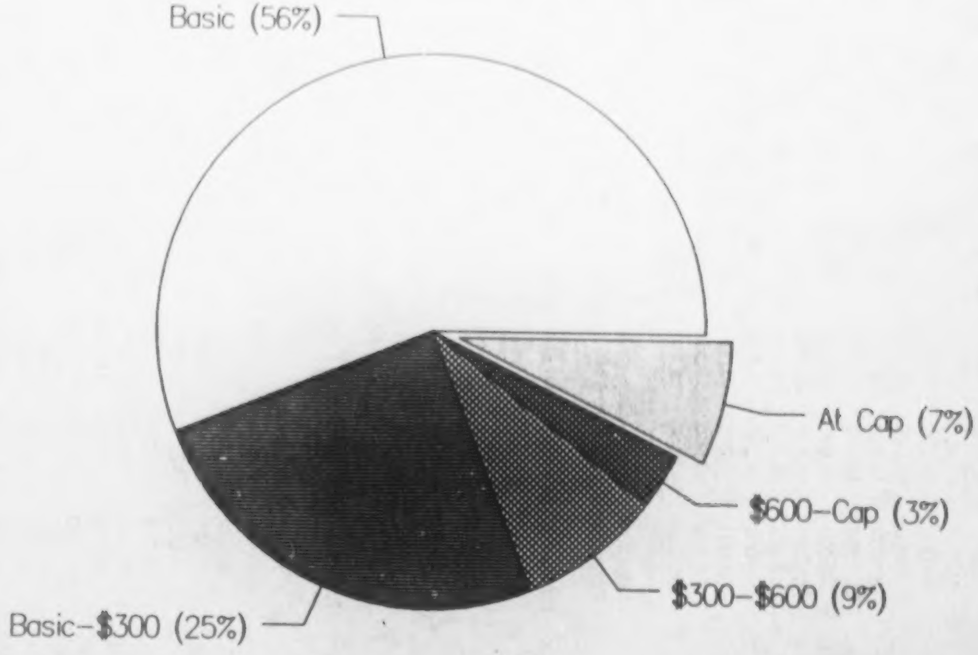
Nontaxed income is equal to excluded social security benefits.
Total premium includes $118 of basic premium.

Source: Price Waterhouse, May 2, 1989

Distribution of Enrollees by Premium Payment, Current Law 1990



Distribution of Enrollees
by Premium Payment, Lower Rates 1990



Current Law
Married Enrollees, Two Age Exemptions, 1993

Total Income	Nontaxed Income	AGI	Itemized Deduction	Taxable Income	Income Tax	Supp. Premium	Total Premium	T. Prem./ Income (%)
$5,000	$5,000	$0	$0	$0	$0	$0	$245	4.9
10,000	9,000	1,000	0	0	0	0	245	2.4
15,000	12,000	3,000	0	0	0	0	245	1.6
20,000	14,000	6,000	0	0	0	0	245	1.2
25,000	14,000	11,000	0	0	0	0	245	1.0
30,000	14,000	16,000	7,500	3,700	555	126	371	1.2
35,000	14,500	20,500	8,000	7,800	1,170	294	539	1.5
40,000	15,000	25,000	8,500	11,800	1,770	462	707	1.8
45,000	13,000	32,000	9,000	18,300	2,745	756	1,001	2.2
50,000	10,000	40,000	9,000	26,300	3,945	1,092	1,337	2.7
75,000	10,000	65,000	10,000	50,300	9,274	2,100	2,345	3.1
100,000	10,000	90,000	12,500	72,800	15,574	2,100	2,345	2.3

Notes:

Nontaxed income is equal to excluded social security benefits.

Total premium includes $245 of basic premium.

Source: Price Waterhouse, January 23, 1989

Current Caps, 70.06 Percent of Current Rates
Married Enrollees, Two Age Exemptions, 1993

Total Income	Nontaxed Income	AGI	Itemized Deduction	Taxable Income	Income Tax	Supp. Premium	Total Premium	T. Prem./ Income (%)
$5,000	$5,000	$0	$0	$0	$0	$0	$245	4.9
10,000	9,000	1,000	0	0	0	0	245	2.4
15,000	12,000	3,000	0	0	0	0	245	1.6
20,000	14,000	6,000	0	0	0	0	245	1.2
25,000	14,000	11,000	0	0	0	0	245	1.0
30,000	14,000	16,000	7,500	3,700	555	88	333	1.1
35,000	14,500	20,500	8,000	7,800	1,170	206	451	1.3
40,000	15,000	25,000	8,500	11,800	1,770	323	568	1.4
45,000	13,000	32,000	9,000	18,300	2,745	529	774	1.7
50,000	10,000	40,000	9,000	26,300	3,945	764	1,009	2.0
75,000	10,000	65,000	10,000	50,300	9,274	1,793	2,038	2.7
100,000	10,000	90,000	12,500	72,800	15,574	2,100	2,345	2.3

Notes:

Nontaxed income is equal to excluded social security benefits.

Total premium includes $245 of basic premium.

Source: Price Waterhouse, May 31, 1989

Current Law
Single Enrollees, 1993

Total Income	Nontaxed Income	AGI	Itemized Deduction	Taxable Income	Income Tax	Supp. Premium	Total Premium	T. Prem./ Income (%)
$5,000	$5,000	$0	$0	$0	$0	$0	$122	2.4
10,000	8,000	2,000	0	0	0	0	122	1.2
15,000	8,500	6,500	0	0	0	0	122	0.8
20,000	8,500	11,500	5,000	4,150	623	168	290	1.5
25,000	8,500	16,500	6,000	8,150	1,223	336	458	1.8
30,000	7,500	22,500	6,000	14,150	2,123	588	710	2.4
35,000	5,000	30,000	6,500	21,150	3,173	882	1,004	2.9
40,000	4,500	35,500	7,000	26,150	3,923	1,050	1,172	2.9
45,000	4,500	40,500	8,000	30,150	4,523	1,050	1,172	2.6
50,000	4,500	45,500	8,000	35,150	6,956	1,050	1,172	2.3
75,000	4,500	70,500	11,000	57,150	13,116	1,050	1,172	1.6
100,000	4,500	95,500	17,000	76,150	19,559	1,050	1,172	1.2

Notes:

Nontaxed income is equal to excluded social security benefits.

Total premium includes $122 of basic premium.

Source: Price Waterhouse, January 23, 1989

Current Caps, 70.06 Percent of Current Rates
Single Enrollees, 1993

Total Income	Nontaxed Income	AGI	Itemized Deduction	Taxable Income	Income Tax	Supp. Premium	Total Premium	T. Prem./ Income (%)
$5,000	$5,000	$0	$0	$0	$0	$0	$122	2.4
10,000	8,000	2,000	0	0	0	0	122	1.2
15,000	8,500	6,500	0	0	0	0	122	0.8
20,000	8,500	11,500	5,000	4,150	623	118	240	1.2
25,000	8,500	16,500	6,000	8,150	1,223	235	358	1.4
30,000	7,500	22,500	6,000	14,150	2,123	412	534	1.8
35,000	5,000	30,000	6,500	21,150	3,173	617	740	2.1
40,000	4,500	35,500	7,000	26,150	3,923	764	887	2.2
45,000	4,500	40,500	8,000	30,150	4,523	882	1,004	2.2
50,000	4,500	45,500	8,000	35,150	6,956	1,050	1,172	2.3
75,000	4,500	70,500	11,000	57,150	13,116	1,050	1,172	1.6
100,000	4,500	95,500	17,000	76,150	19,559	1,050	1,172	1.2

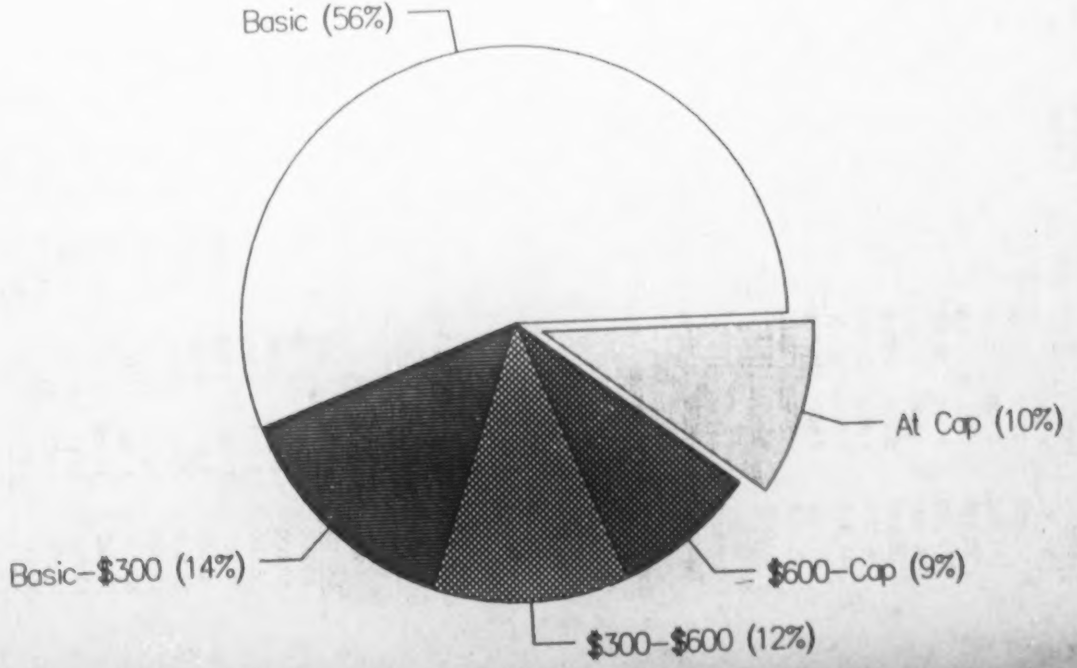
Notes:

Nontaxed income is equal to excluded social security benefits.

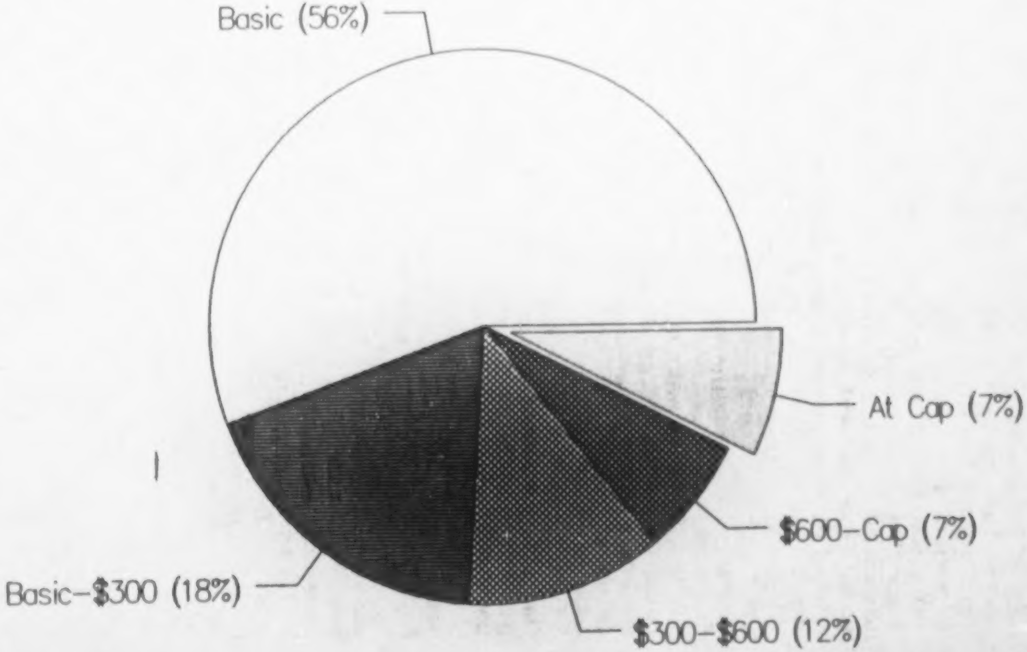
Total premium includes $122 of basic premium.

Source: Price Waterhouse, May 31, 1989

Distribution of Enrollees by Premium Payment, Current Law 1993



Distribution of Enrollees by Premium Payment, Lower Rates 1993



PREPARED STATEMENT OF SENATOR JOHN H. CHAFEE

Mr. Chairman, I applaud you for calling this hearing. As a committee, we have the critical responsibility to exercise continuing and careful oversight of the Catastrophic Coverage Act as it goes into effect.

I take this oversight responsibility seriously. We developed the Catastrophic Coverage Act in response to a very real need expressed by senior citizens for protection against the possibility of being wiped out financially by a single illness. I believe that we have created a good package of benefits to meet that need. Now, as the program is going into effect, we need to keep a watchful eye for any changes that may be warranted.

We now have a new revenue estimate from CBO which shows receipts to be higher than we originally projected. There will be another estimate, and another one after that. At this point, these are all just estimates—they are not based on any actual experience with program costs or receipts. I have the utmost respect for the work of the Congressional Budget Office, and they, being good actuaries, will be the first to tell you about the vast uncertainties that are inherent in their estimates. But frankly, since collections of the supplemental premium have not even begun yet, I am hard pressed to understand why this new estimate is any more likely to be accurate than the old estimate. If the excess reserves that are now projected do in fact occur, we will certainly be able to step in and make adjustments to the premium. In fact, the law contains a mechanism which will automatically correct the premium if too much revenue is collected in the early years of the program. But I must say I have serious reservations about making changes now, before we even begun to collect the supplemental premium and before we have any experience with actual costs.

I am certainly open to giving due consideration to any and all proposals for change in the catastrophic program. As my colleagues will remember, the bill we passed here in the Senate contained a provision making catastrophic coverage optional. This would have meant that any Medicare beneficiary could have opted out of Part B coverage, and thus opted out of the catastrophic program—and thus opted out of paying catastrophic premiums. This would have meant that he or she could have examined the benefits and the costs, and made an informed decision. Personally, I would opt in, because I believe you can not get better coverage for the price in the private market. CBO has done a report that bears this out, showing that the government subsidy on Medicare benefits is substantial across all age and income categories—even for those who will pay the maximum supplemental premium.

This provision making catastrophic coverage optional was deleted in the face of objections from the House. Perhaps that is what we should be renegotiating here, instead of going back and forth over revenue estimates. Making catastrophic coverage optional would certainly be a more meaningful way to address the controversy over the new program than tinkering with the supplemental premium.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF CONGRESSMAN HARRIS W. FAWELL

MR. CHAIRMAN, I WOULD LIKE TO THANK YOU FOR GIVING ME THIS OPPORTUNITY TO APPEAR BEFORE THE COMMITTEE THIS MORNING.

I AM SPONSORING LEGISLATION IN THE HOUSE, H.R. 169, TO REPEAL THE MEDICARE CATASTROPHIC COVERAGE ACT (MCCA) AND FORM A COMMISSION TO STUDY WHAT SHOULD REPLACE IT. I'M ALSO COCHAIRING, WITH CONGRESSMAN BILL ARCHER, THE HOUSE REPUBLICAN RESEARCH COMMITTEE'S TASK FORCE ON THE CATASTROPHIC LAW; THERE ARE 47 MEMBERS ON THIS TASK FORCE. THE TASK FORCE WILL BE HOLDING A HEARING ON THE LAW ON JUNE 26TH. MR. CHAIRMAN, THE OPPOSITION TO THIS ACT IN THE HOUSE IS BUILDING -- THERE ARE NOW 178 MEMBERS OF THE HOUSE COSPONSORING LEGISLATION TO REPEAL, DELAY, OR SCALE BACK SHARPLY THE CATASTROPHIC PROGRAM.

THE MEDICARE CATASTROPHIC COVERAGE ACT (MCCA) IS AN EXPANSION OF MEDICARE IN THE WRONG DIRECTION. IT IS AN EXPANSION COMPLETELY IGNORING SENIOR CITIZENS' HIGHEST PRIORITY OF HEALTH CONCERNS, WHICH IS LONG TERM CUSTODIAL NURSING HOME CARE. IT IS ALSO FINANCED IN THE WORST OF ALL WAYS - BY A NEW INCOME TAX TO BE PAID MOSTLY BY MIDDLE-INCOME SENIORS.

THE ACT MANDATES THAT SENIORS WHO PAY INCOME TAXES AND ARE ELIGIBLE FOR MEDICARE WILL FINANCE MOST OF THIS VAST EXPANSION OF MEDICARE. THEY WILL ALSO BE SUBSIDIZING BENEFITS FOR OTHERS. EVEN THOUGH MOST ARE ALREADY COVERED BY EMPLOYER-PROVIDED OR OTHER PRIVATE "MEDI-GAP" INSURANCE.

HAD CONGRESS ASKED SENIORS, THEY WOULD HAVE BEEN TOLD SENIORS' HIGHEST PRIORITIES FOR NEW HEALTH CARE COVERAGE ARE LONG TERM CUSTODIAL NURSING HOME CARE, FOLLOWED CLOSELY BY IN-HOME CUSTODIAL HEALTH CARE. NEITHER OF THESE HEALTH COSTS ARE COVERED BY MEDICARE. MOREOVER, PRACTICALLY SPEAKING, SENIORS CANNOT OBTAIN PRIVATE INSURANCE COVERAGE FOR THESE TYPES OF CARE. THAT IS WHY LONG-TERM CUSTODIAL NURSING HOME CARE IS THE TRULY "CATASTROPHIC" FEAR OF MOST SENIORS AND COUNTLESS AMERICAN FAMILIES.

CONGRESS DID NOT ASK SENIORS WHAT THEY WANTED MOST. NOW THEY ARE TELLING US. HUNDREDS OF THOUSANDS ARE WRITING CONGRESS IN OPPOSITION TO THE NEW LAW. EVERY MEMBER I KNOW IS GETTING AN EARFULL EVERY TIME THEY RETURN TO THEIR DISTRICT.

AN EXCELLENT SURVEY OF MIDDLE-INCOME SENIORS BY THE WIRTHLIN GROUP PROVIDES STRONG EVIDENCE OF THE UNPOPULARITY OF THE LAW. MOST OF THOSE RESPONDING HAD INCOMES UNDER $20,000. 84 PERCENT SAID THEY ARE ALREADY COVERED BY MEDIGAP INSURANCE. A LONG-TERM PROGRAM IS PREFERRED TO THE CURRENT LEGISLATION BY A 65 TO 19 PERCENT MARGIN. WHEN ASKED TO CHOOSE BETWEEN A STATEMENT SAYING THAT "THE FEDERAL GOVERNMENT SHOULD ASSUME THE COMPLETE RESPONSIBILITY FOR PAYMENT OF HEALTH CARE FOR SENIOR CITIZENS" OR "THE ELDERLY SHOULD SHARE THE RESPONSIBILITY WITH THE FEDERAL GOVERNMENT," THE LATTER PREVAILED 52 PERCENT TO 35 PERCENT.

SHOULD CONGRESS HAVE ASKED SENIORS THESE QUESTIONS BEFORE WE ENACTED CATASTROPHIC? I THINK SO! ESPECIALLY SINCE WE ARE ASKING THEM TO PAY FOR IT. MCCA IS A "MANDATED BENEFITS" PROGRAM FOR ALL SENIORS AND DISABLED PERSONS ELIGIBLE FOR MEDICARE. IT IS ONE THING FOR CONGRESS TO CREATE A NEW PROGRAM FOR WHICH ALL TAXPAYERS WILL PAY. IT IS QUITE ANOTHER TO PLACE A SPECIAL TAX ON ONE GROUP, ASK THEM TO SUBSIDIZE OTHERS, THEN MANDATE UPON THEM BENEFITS WHICH DO NOT MEET THEIR PRIORITIES.

MCCA IS FINANCED BY THE INNOCUOUS SOUNDING "SUPPLEMENTAL PREMIUM." BUT IF IT WALKS AND TALKS LIKE A DUCK, IT IS A DUCK. AND, MR. CHAIRMAN, THE SUPPLEMENTAL PREMIUM IS AN INCOME TAX.

IN PASSING THE 1986 TAX REFORM ACT, CONGRESS PROMISED IT WOULD NOT TURN AROUND AND INCREASE INDIVIDUAL INCOME TAX RATES IN THE NEAR FUTURE. YET IT HAS NOW DONE PRECISELY THAT TO THE ELDERLY MIDDLE-INCOME AMERICANS, PEOPLE WHO, WITH THE URGING OF CONGRESS, SAVED AND LIVED FRUGALLY BY AND LARGE OVER MANY YEARS SO AS NOT TO BE SOLELY RELIANT ON SOCIAL SECURITY FOR THEIR SUPPORT DURING RETIREMENT. THESE ARE THE SAME PEOPLE WHO ARE MOST OFTEN FACED WITH THE CHALLENGE OF LIVING ON A FIXED OR DECLINING INCOME. MANY OF THEM ARE ALSO RESTRICTED BY THE SOCIAL SECURITY EARNINGS TEST FROM EARNING ADDITIONAL FUNDS TO MEET HIGHER COSTS OF LIVING, INCLUDING HIGHER TAXES.

IN ADDITION, THE INCOME TAX PLACED UPON SENIORS BY THIS ACT IS A TAX UPON A TAX, GUARANTEEING A "DOUBLE-HIT" AGAINST SENIORS IN FUTURE YEARS WHEN CONGRESS INCREASES INCOME TAXES EITHER BY REDEFINITIONS OF TAXABLE INCOME OR CHANGES IN RATES. AS THIS OCCURS, THOSE WHO MUST PAY A SURTAX ON THE INCOME TAX WILL PAY SUCH AN INCREASE TWICE - FIRST, THE INCREASE IN THE TAX AND SECOND THE SURTAX, A TAX UPON THE TAX.

CONGRESS SHOULD GO BACK TO THE DRAWING BOARD AND ADMIT THAT BOTH MODE OF FINANCING ARE FLAWED. THE ACT SHOULD BE REPEALED OR DELAYED FOR AT LEAST TWO YEARS WHILE A COMMISSION REEXAMINES HOW ELDERLY HEALTH CARE SERVICES MAY BEST BE EXPANDED AND HOW ITS COSTS MAY BEST BE FINANCED. THE PRIVATE SECTOR SHOULD BE CONSIDERED AS HAVING A PART TO PLAY.

IF CONGRESS HAS NOT GOT THIS MESSAGE YET, I CAN ONLY SAY, "YOU AIN'T SEEN NOTHIN' YET." WHEN MILLIONS OF SENIORS FILE THEIR INCOME TAX RETURNS NEXT APRIL, THERE IS GOING TO BE A POPULAR REVOLT THE LIKES OF WHICH HAVEN'T BEEN SEEN SINCE THE REPEAL OF "INTEREST WITHHOLDING" SEVEN YEARS AGO.

Prepared Statement of Senator Tom Harkin

Mr. Chairman and members of the Committee, I appreciate this opportunity to offer my thoughts and recommendations on the Medicare Catastrophic Coverage Act.

The catastrophic bill passed last year filled a very real need for our older citizens—Medicare coverage for the high costs of a protracted illness or accident. Unfortunately, the method for financing these benefits proved to be a stumbling block.

President Reagan said he would veto the legislation unless it was "self-financing"—in other words, unless the beneficiaries footed the bill. Congress faced a choice approve a bill that was not Ideal, with the hope we could fix the problems later—or let the opportunity pass, and face the possibility many years would go by before another chance came to extend catastrophic coverage to Medicare beneficiaries.

The financing that was approved combines a flat monthly premium on all beneficiaries—plus a supplemental premium based on federal income tax owed. While this financing mechanism was not as good as it could be, it was certainly better than it might have been. For example, total financing of catastrophic benefits by a regressive flat premium supported by President Reagan—would have put a severe strain on low-income elderly persons.

Nevertheless, the supplemental premium—or surtax has many older Americans up in arms, and rightly so.

In senior citizen town meetings across Iowa, I've heard the same theme repeated—keep the program, change the financing. Frankly, I believe their request is more than reasonable.

As a nation, we do not accept the argument that government benefits should be paid for solely by the beneficiaries. Students do not bear the total cost of their education. Farmers are not shouldered with the entire cost of farm programs. We all pay into and benefit from Social Security.

Older Americans are willing to pay into this program, but now they pay the highest marginal tax rates in our country.

As a result of the current catastrophic financing system, some senior citizens will have to pay effective income tax rates of 40 percent and higher. Older Americans are not asking for a special break—only the same treatment accorded every other American.

Restoring this fairness is the purpose of The Medicare Catastrophic Coverage Surtax Repeal Act of 1989 which I have developed with Senator Levin and Congressman Bonior.

As its name indicates, this bill eliminates the catastrophic surtax—or supplemental premium—entirely.

The bill preserves all of the benefits of the Medicare Catastrophic Coverage Act.

The revenue from the supplemental premium is replaced by extending the existing 33 percent tax rate which was effectively created in the 1986 Tax Act by the phase out of personal exemptions and the 15 percent rate to the highest income taxpayers. In 1986, an anomaly was created. A family of four with taxable income from $78,350 to $208,510 (and single filers with incomes between $47,000 and $109,050) in 1990 pay the extra five percent tax. But, those 600,000 highest earning taxpayers pay only 28 percent on their taxable income above those amounts. It is our view that these are the taxpayers, the single taxpayer with a taxable income of over $109,000 or a joint filing taxpayer with over $209,000 in taxable income, who are most capable of bearing the burden of catastrophic care for those in need.

Our legislation sets the long term capital gains tax rate at 28 percent for the 33 percent bracket. At the present time, those taxpayers in the existing 33 percent "bump" pay 33 percent on their long term capital gains. So, for some taxpayers, there will be a tax reduction under this legislation.

This proposal is virtually revenue neutral over five years.

Revenue from the additional taxes raised under our measure would flow to the same trust accounts into which the supplemental premium would have gone. Any shortfall that might occur would be made up with general revenues and then would be repaid by the additional taxes raised in the following period, as calculated by the Treasury. From Joint Tax estimates, revenues in the out years would more adequately meet program needs than the present supplemental premium.

Since the flat monthly premium would be preserved, the elderly would still be paying substantial portion of the cost of the catastrophic program. The flat monthly premiums would cover about 40 percent of the program cost, higher than the 25 percent paid by the elderly under the Medicare Part B program.

In the 1986 Tax Act, the very wealthy saw a reduction in the top tax break from 50 percent to 28 percent. That followed a reduction from 70 percent to 50 percent in the 1981 Tax Act.

The dramatic reduction in taxes in 1981 was a clear windfall for the very wealthy. The loss of revenue from the 1981 Act is one of the major reasons for the huge increases in the budget deficits in the early 1980s.

In 1986, we saw a further reduction in the top bracket. In that case, there was a significant reduction in deductions, exclusions and credits which allowed many of the wealthy to avoid paying the effective percentage of tax paid by many moderate income taxpayers. Some very high income taxpayers, with incomes of more than $200,000 per year who had really worked at sheltering their income from income taxes, did see an increase in taxes because of the 1986 Tax Act. However, a considerable majority of very high income taxpayers actually saw a reduction in taxes. In 1986, as the bill passed, it was estimated that the average decrease in taxes for those making more than $200,000 per year who would receive reductions in taxes would, on average, see their taxed drop by more than $59,000 per year!

A lot has been said about the need to preserve the 28 percent top bracket. But we now have an effective 33 percent tax on those with income covered by the "phase out rule" or as it is sometimes called, "the bump." Our bill restores the concept that those with the highest incomes pay the highest marginal rate of tax.

In addition, the surtax imposed on the elderly under the Medicare Catastrophic Coverage Act is a far greater modification of the rate structure established by the Tax Reform Act of 1986. As a result of the catastrophic law, some middle and upper income senior citizens have to pay higher tax rates than the rest of the population and will in some cases have an effective income tax rate of over 40 percent. By repealing the surtax, our bill would have senior citizens pay the same income tax rates as everyone else.

When the catastrophic benefits were first proposed, the Reagan Administration insisted that the elderly would have to pay for all of the benefits themselves. This is a clear departure from past precedent. The Medicare Part B program has traditionally been financed three-quarters from general revenues and one quarter through premiums paid by the elderly. And, the general rule is that beneficiaries in need receiving benefits from federal programs should be paid for by the society as a whole. I believe that same principle should be restored to Medicare. The elderly are not a group apart, separate and removed from society. Why should the financial burdens of the lower income elderly fall more heavily on the middle income elderly than on society as a whole?

We all bear responsibility for the needs of the young and old. We all receive, to some extent, relief when assistance is given to the elderly. Many of us here have elderly relatives who will make use of the benefits of Medicare Catastrophic Coverage Act in the coming years.

I want to stress that "we need to preserve the benefits provided by the Catastrophic Coverage Act. The law moves to close gaps in the coverage provided under Medicare. It provides a cap on out-of-pocket expenses for physician and hospital care, an important new drug benefit, mammography screening coverage, protection from spousal impoverishment as well as skilled nursing facility and resite relief benefit improvements

Prior to enactment of the catastrophic care legislation, many private employers provided similar benefits to their retirees. The federal government also provided some of these benefits to federal retirees. And, many individuals purchased their own private medigap policies to take over where Medicare was leaving off. Obviously, these benefits were properly viewed by many employers and individuals as being extremely important.

But there is always the possibility that a private employer will go bankrupt. We already have examples of such bankruptcies where covered employees lost their insurance. Many individual medigap policies have been shown to be far from cost effective. And, most important, approximately one-fifth of the elderly, generally lower income seniors, did not have any catastrophic coverage prior to passage of this law. These persons simply could not afford to purchase coverage on their own. And they were not covered under any employer-sponsored health program. The catastrophic law represents the only means of providing these persons with this coverage.

I want to emphasize that the elderly are not getting a free ride under the proposal we are offering. Under our bill, seniors still have to pay the substantial monthly premiums to help pay for the catastrophic benefits. These flat premiums will cover almost 40 percent of the cost of the entire program. This is considerably higher than the 25 percent paid by the elderly for the Medicare Part B program.

And, under our measure, wealthy senior citizens will have to pay the 33% tax rate, just like other taxpayers. Thus, they will also be helping to defray the costs of the catastrophic care benefits through this mechanism.

This is the first bill to fix catastrophic financing that has wide support from senior citizen groups and organizations representing workers and retired workers. Among the groups that have already endorsed this bill are the National Council of Senior Citizens, the National Association of Letter Carriers, the National Council on the Aging, the National Committee for the Preservation of Social Security and Medicare, the United Auto Workers, the Grey Panthers, the American Postal Workers Union, and AFSCME.

So we're proud to offer this legislation. We believe it offers a straightforward, fiscally-responsible, and fair solution to the problems caused by self-financing of catastrophic care.

This bill offers real tax relief to older Americans by closing a loophole for wealthy taxpayers that should be closed. It fixes catastrophic financing without endangering the benefits.

It's a strong, workable approach—and one we hope the Committee on Finance will support. Thank you.

PREPARED STATEMENT OF SENATOR ORRIN G. HATCH

Mr. Chairman, I want to thank you for scheduling this hearing. I am pleased to join Senator McCain and the other senators gathered here today to represent the views of their senior constituents regarding the Medicare Catastrophic Care Act of 1988. Seniors in my home state of Utah and around this country are up in arms because they are being forced into purchasing a government health benefit which they do not necessarily need or want.

I have received thousands of letters from Utahns who oppose the Medicare Catastrophic Care Act. They oppose it for three reasons. First, they do not like the cost of the plan. Second, they do not like the particular benefits that Congress has dictated that the plan include. And, third, and perhaps most important, they do not like the federal government mandating that they must participate in this new program.

During a senior's conference I recently sponsored, I polled Utah seniors to determine their views on the Medicare Catastrophic Care Act. While almost two-thirds of those surveyed felt that the federal government should provide seniors with protection from the financial losses of a catastrophic illness, *85 percent* of all of those surveyed felt that seniors should be allowed to choose whether or not they participate in the program.

I voted for this Act because I firmly believe that seniors do need to be protected from the financial devastation of catastrophic illness. But I remain committed to the idea that this program should be voluntary. Seniors in America deserve freedom of choice. Some of the architects and supporters cf this bill have called it the "best buy in town." If this is true, I suggest that we let informed seniors decide whether or not they want to avail themselves of it.

Mr Chairman, I believe we in Congress must respond to the persistent voices of American seniors protesting the usurpation of their freedom of choice. I applaud this Committee's willingness to revisit the Medicare Catastrophic Care Act. During these discussions, I encourage the Committee to reexamine not only the cost and financing of this Act, but also the questions of whether or not the benefits covered by the plan are those desired by seniors and how we might make this plan voluntary. I am eager to assist this Committee in any way possible during this endeavor, for I firmly believe that we in Congress must provide an immediate legislative response to the overwhelming opinions of those we represent.

PREPARED STATEMENT OF DANIEL L. HAWLEY

PROBLEM

The largest expansion of Medicare since its inception began in an innocuous manner, with a request for legislation which would "remove a financial specter facing our older Americans." It was originally intended to be accompanied by a small increase in Medicare premiums. What was propelled out of the Conference Committee, debated and voted on in haste with little or no study, heavily lobbied by AARP, and passed and signed in an Election Year to gain favor with the Seniors, has turned out to be the heaviest penalty ever assessed on one segment of American Society, the Seniors of America.

THE SENIORS COALITION AGAINST THE MEDICARE CATASTROPHIC ACT

The Seniors Coalition Against the Medicare Catastrophic Coverage Act, hereinafter referred to as SCACA, was formed in Las Vegas, Nevada, on August 22, 1988. SCACA has become a national clearinghouse for Seniors who are either unrepresented by national organizations, are members of large national organizations which are not listening to the demands of their membership, or belong to smaller organizations which are not formally considering the impact of the Medicare Catastrophic Act (see Appendix A for List of Organizations).

THE NATIONAL PETITION TO REPEAL H.R. 2470 (PL 100-360)

On October 13, 1988 in Las Vegas, Nevada, SCACA introduced the National Petition to Demand the Repeal of H.R. 2470. This petition is in response to the requests of thousands of registered voters who want to sign a document which expresses their vehement opposition to this Act.

346,427 signatures have been received and hand-counted. The signatures are arriving at the rate of almost 50,000 per month. They are continuing to pour in and show no signs of slowing down. An illustration of the growing anger of the Senors is the 12,000 signatures received from the State of Texas in three weeks.

SCACA MEMBERSHIP SURVEY

In March of 1989, in response to the anger expressed by Seniors across the country regarding the AARP Survey, SCACA initiated its eleven-question survey (Appendix C). The questionnaire was designed to survey the grass-roots population and therefore was not only circulated by SCACA but also published in Senior's newspapers throughout the United States in order to reach the greatest number of Seniors.

7,921 Surveys have been returned and the answers have been hand-tallied. 86% or 6,847 of the respondents are over 65 years of age. The responses to the Survey questions are contained in Appendix C.

Contrary to the Congressional myth that Seniors do not understand the Act and that when it is explained to them they will love it, 6,139 people, or 78% state that they do understand the Medicare Catastrophic Coverage Act, and 7,137 or 90% answered that they do not believe that the Act provides enough benefits for the increased costs. 7,053 or 89% believe the Supplemental Premium is UNCONSTITUTIONAL.

The disparities between a random telephone survey of 1,750 people age 45 and older which was conducted by Hamilton, Frederick and Schneiders, for the American Association of Retired Persons and the SCACA grass-roots survey of 7,921 are clearly demonstrated in the answers to Questions Nine and Ten.

6,297, or 79% of the people surveyed stated that they are members of AARP. 91% or 7,213 stated that AARP does NOT represent their opinion in its support of the Medicare Catastrophic Care Act. Only 407, or 5% of the 7,921 respondents stated that AARP represents their opinion in supporting this Act.

Quite truthfully, the answers to Questions Seven and Eight were the greatest surprise to SCACA. These questions were included in the Survey to allow the Seniors to express their concerns regarding Long Term Nursing Home Care and Long Term Home Care. Their responses were unexpected. The Seniors were not content to answer "yes" or "no"—their answers centered around their growing mistrust of any program run by the Government and their growing distrust of Insurance Companies. (Many of these people were participants in AARP's Medigap Insurance Plan and their premiums were increased an average of 40% on January 1, 1989, despite the fact that Seniors were assured by Congress that Medigap premiums would be reduced with the enactment of this law).

SENIOR POWER

The Seniors of America are angry, are growing more angry daily, and their numbers are growing as new questions about this Act materialize. A petition drive in a mall in a California City displayed a banner "Stop the Big Rip-Off". The table was manned by volunteers from TROA, NARFE, AARP and SCACA. I quote from the organizer of the drive "Most encouraging was the participation of young registered voters . . . One can only guess that they have heard about it from parents, grandparents etc." Another Rally held in New York, was announced with a flyer proclaiming "We will remember in November."

Congress appears to have forgotten that the Government is "of the people, by the people and FOR the people." Consequently, Seniors have written for months, "When will we march on Washington?" SCACA has predicted that, if this Act is not RE-

PEALED, beginning in 1990 there will be the largest turn-over in Congress in its history.

MAJOR PROBLEMS WITH THE MEDICARE CATASTROPHIC COVERAGE ACT

It has been said many times in the past year, that if you must fight for REPEAL of a piece of legislation, this Act is perfect because it has something in it for everyone to hate. But, it is not just the minuscule benefits and the huge mandatory payments which make this Act unconscionable, it is the number of unanswered questions about the benefits, the premiums, the numbers and ages of the beneficiaries, the projected financial status of the Trust Funds, the ongoing reduction of benefits in the current Medicare Plan, and the question as to whether Congress will be able to borrow from the Trust Funds as they do Social Security.

The Institute for Research on the Economics of Taxation Report, February 24, 1989, stated that, even with the fact that there are 32.6 million persons enrolled in Medicare, only a small percentage will actually receive benefits from the Catastrophic Coverage Act. For example, only 7.2 percent of enrollees are expected to incur large enough hospital expenses to receive benefits under Part A. (In the IRET Report, Page 16, Table 7, August 1, 1988, the Congressional Budget Office states, "only 6.8 percent of enrollees can be expected to be in the hospital two or more times a year and only 0.5 percent can expect an extremely long stay").

By law, the Part B Co-payment Cap will be set so that only 7 percent of enrollees will have Part B expenses that exceed the cap, and the drug deductible will be set so that only 16.8 percent of enrollees can exceed it.

The alarming revelations of an internal Health Care Finance Administration (HCFA) document entitled, "Options for Preventing Insolvency of the Medicare Catastrophic Drug Insurance Trust Fund" point out that far less than 16.8 percent of enrollees actually will receive benefits from the Drug Insurance Trust Fund, the most costly portion of this Act, because of insolvency. The HCFA actuaries now predict a deficit in the Catastrophic Drug Insurance Trust Fund in 1991 of almost $500 million. By the end of 1993, if no action is taken, the Trust Fund deficit is estimated to reach $4.5 billion. And that statement is just for openers. Although I have included what I assume to be the complete document, I would be remiss if I did not highlight the first two pages for the Committee. I quote, "While the general level of these estimates is no secret to informed observers, they will become publicly obvious with submission of the 1990 Budget to Congress":

- To account for what would happen once the Trust Fund is depleted, the HCFA budget submission assumes we would hold claims until more money was available. The resulting backlog of claims would quickly become substantial.
- While this assumption fills the need for logical consistency in the budget, if it remains in the budget sent to Congress in January we will be open to questions and possible embarrassment regarding our policy stance.

While we may or may not wish to seek legislation to remedy the problem at this time, we need to consider what our policy should be in case a solution is needed quickly.

Congressional Interest

While Congress has given the Secretary very little room for movement in this area, it is definitely alert to the potential problem. Congress has mandated that we report on drug usage by Medicare beneficiaries in May and November of 1989 and 1990 and in May of each following year. Congress also required the Secretary report by April I, 1989 on expenses of Medicare beneficiaries for prescription drugs using data from the 1987 National Medical Expenditure Survey (NMES) (which may be delayed). CBO then has 60 days to revise its drug outlay estimates. Options to Prevent Insolvency

The Medicare Catastrophic Coverage Act sets virtually all of the financial parameters relating to the drug benefit in the first few years and gives the Secretary very little authority to address the problem of insolvency. Attached is an option paper that explores possible legislative solutions to these financial problems. Three options are presented:

- A "premium strategy," which relies on increased premiums, but makes no change in coinsurance and deductibles.
- A "deductible strategy," which increases deductibles and coinsurance but does not change premiums.
- A "mixed strategy," which would change all three.

Timing of Proposal

We must also decide when we should advance a proposal. We see three distinct possibilities:

- We could advance a proposal now that could eventually become part of the 1990 budget submission to Congress.
- We could defer until next summer, after more up-to-date survey data becomes available.
- We could wait until 1991, after the benefit has been fully implemented and information based on operation of the program is available.

Submitting a proposal now allows us to "seize the high ground" by advancing a solution at the same time we are revealing the problem. This strategy would make it clear that we take the problem seriously and are prepared to deal with it, rather than hope more information will cause it to go away. It would give us more influence over the terms of the Congressional debate, and would also dramatize the magnitude of the problem, which may help make Congress more cautious as it considers other possible program expansions."

This glaring admission by HCFA and the suggestion by Senator Bentsen that a REDUCTION in the Cap of the Supplemental Premium be enacted as a solution to make the Act more palatable to the Seniors, highlights the contradictory information which surrounds this Act. It also clearly illustrates that the massive health care needs of America cannot be addressed by a Bi-partisan Committee of Congress. They do not have the time to conduct the necessary study. It has been my experience that no matter what you call a committee, if you do not change the participants, you do not change the thinking. This Act must be repealed and the study of American Health Care taken out of the political arena.

Another misreading of the uproar that has come from the grass roots of America is Senator Bentsen's concept that only the "rich Seniors" are protesting. A classic example of how concerned "rich Seniors" are is the fact that an airline pilot retirees group could not find even five minutes in their agenda to discuss the financial impact of this Act on their personal retirement income. Quite the contrary, it is the low-income and the middle-income Seniors that are creating the uproar. The reason is that they have found out that it is their level of income that will be hurt the most.

THE AMERICAN HEALTH PLAN

Even though it is the continuing belief of SCACA that the solutions to the health care needs of all Americans be placed in the hands of an appointed Commission of Health Care Experts (excluding any self-vested interests and members of Congress), we are asked "If you don't like the Medicare Catastrophic Care Act, what do you propose?" SCACA proposes the following cooperative plan to identify and address the actual medical needs of all members of American Society. The success of this plan depends on enforcement of the complete strict cooperation of four separate sectors of the American Society:

1. The Beneficiaries. All American beneficiaries must be willing to bear a realistic and FAIR share of the cost. but, contrary to the concept of the Catastrophic Act, not bear all of the costs. (The IRET Report states that the amount of benefits received by the non-aged will be twice that received by the elderly under the Medicare Catastrophic Coverage Act).
2. The Insurance Companies. The participation of the Insurance Industry must be mandatory. Their cooperation to participate by providing an affordable and realistic "American Health Care Policy" for all Americans is an absolute must for any plan to succeed. Contrary to their protestations, they can produce an equitable policy and still remain profitable—they must be willing to exchange short-term goals for long-term goals.
3. The Medical Providers. Cooperation from The Hospital Association, American Medical Association, the Pharmaceutical Industry, Nursing Profession, Nursing Home Care Providers and all other Health Care Providers must be mandatory. These industries have contributed to the cost of medical care in the United States rising a minimum of 16% annually. This must be stopped if we are to gain fiscal control of Health Care. Priorities must change so that people in need of medical care are not "captives" of the system to be charged whatever price, and, if they cannot pay, be forced to go without or receive lesser treatment.
4. The Government. The Government, and Congress, must recognize their duty to their people by placing the highest priority on Health Care and must back up that commitment with the necessary Budget Appropriations to pay its FAIR share of the

costs of the American Health Care Plan. The Government and Congress must stop the "piecemeal" approach and take Health Care out of the "Tomorrow" file.

It will require courage to force a complete cooperative effort in the provision of health care and it will require a drastic change in thinking from "what is in it for me" to "what is in it for America". Revolutionary? Now is the time to restore the trust in Congress and the Government to its people. You gentlemen are here representing your States in the Senate, because you have a vision of what America is and you know that there exists the intelligence and the skill to solve this awesome and growing problem.

It is not only the "graying of America" that has placed such a burden on the American Health Care System. There are many more difficult and expensive problems confronting the Health Care Field than those created by the aging. Many thousands grow old without encountering catastrophic diseases; many thousands live a good and productive life without ever needing Long Term Care. The problem is to identify what the Health Care needs of America actually are, how many people need help with these needs and what that help costs. Allow the Seniors to do what they have always done best—retain their self-reliance and self-pride. Identify and help those who need help and allow the rest their independence.

Some very important points must be made so that the Committee clearly understands what the grass-roots is saying when they say REPEAL. It is not solely the funding mechanism that they object to, it is the entire costly and inadequate Act. They do not want any part of it. The minute benefits that exist in the Act, which will help the poor elderly, may easily be incorporated into the present Medicare program, since even Congress has stated that the costs for those benefits are negligible.

The Medicare Catastrophic Coverage Act must be REPEALED!

APPENDIX A—LIST OF SUPPORTING ORGANIZATIONS

ARCO-Anaconda Club
Atlanta Jewish Community Center, Inc.
Bay Ridge Community Council
Blanchard Area Seniors in Corporation
Bremem Township Senior Citizen's Organization, Inc.
Burlington Northern Railroad Veterans
Carbide Retiree Corps. Inc.
Central Florida Legal Services, Inc.
CHEER, Sussex County Senior Services, Inc.
City of Phoenix Retirees Association
Clinton County Senior Citizens
Coalition for Alternatives in Nutrition & Healthcare, Inc.
Committee for Repeal of the Catastrophic Health Act of 1988
Committee to Alert People
Delta Airlines Pioneers Club
First of Michigan Corporation
Ford Retirees
GAF Linden Employees Federal Credit Union
Gray Panthers
Huntcliff Summit Retirement Community
Illinois Retired Teachers Association
Jewish Community House of Bensonhurst
Kirby Pines Residents Association
Knights of Columbus
Lapeer County Commission on Aging
Madison Area Retired Teachers Association
Mansfield Township. Burlington County, New Jersey
National Alliance of Senior Citizens
National Association of CCC, Luther Burbank Chapter 131
National Association of Retired Federal Employees
Navistar/West Pullman Retirees' Club
NCSU Faculty Association
North Carolina Senior Citizens Association
Oakland County Taxpayers Association
Ohio Association of Senior Centers
Orange Elderly Services, Inc.
Retired Employees of the City & County of San Francisco
San Joaquin County Senior Advocacy Council, Inc.
Senior Citizens Club, Forest Park, Il

Senior League of Pikes Peak Area
Seniors for Action
Seniors United
Silver State Mobile Home Owners Association
St. Pius X Senior Fellowship Club
State Employee Retirees Association, Lansing, MI
State of Washington, Governor's State Council on Aging
Sun City Center Residents Against Medicare Catastrophic Coverage Act
Telephone Pioneers of America
Temple Gates of Zion, Valley Stream Jewish Center
The Retired Officers Association
Town of Barnstable Council on Aging Senior Citizen Center
TWA Local 1056 Senior Club
UAW Retirees, Orlando, Florida
Veterans of Foreign Wars of the United States, Mountainside Memorial Post
Veterans of World War II, Navy Mortar Torpedo Boat Squadron
Waterford Senior Citizen Program
West Hartford Senior Center

APPENDIX B

SCACA

THE SENIORS COALITION AGAINST THE MEDICARE COVERAGE ACT OF 1988

HR 2470

PETITION

WHEREAS Congress passed and President Reagan signed into Law on July 1, 1988, the Medicare Catastrophic Coverage Act of 1988 (HR 2470); and

WHEREAS this legislation does not address nor cover most catastrophic care costs for senior citizens, and does not cover most nursing home care, and therefore should be identified and accepted as fallacious in its titling and representation; and

WHEREAS this legislation creates an unprecedented form of direct, affinity taxation on senior citizens, at rates far higher than any other segment of the American population; and

WHEREAS this legislation was fraudulently represented to senior citizens and the American public on its very high costs, very limited coverage and protection, its new, unprecented and harmful taxation method, and its unlimited escalation potential for Congress to add any expansions--even to cover other age groups--that it wants to enact; and

WHEREAS Congress has, at the very same time of passage of this legislation, reduced actual coverage and benefits to senior citizens through Medicare; and

WHEREAS Congress has not addressed the non-coverage and gaps in Medicare which means that senior citizens will continue to pay more than sixty percent of their medical costs; and

WHEREAS this legislation presents the full, added payment demand on senior citizens, meaning that senior citizens are and will fund in the future most of the medical costs of AIDS patients; and

WHEREAS this legislation is so limited in its coverage with present and future costs so high in premium increases, new premiums, and new, direct taxation to senior citizens; and

WHEREAS this legislation, HR 2470, attacks and charges its costs to any and all senior citizens who attempt to provide for their own retirement through productive investments or continued work;

THEREFORE we the undersigned voting Citizens of the United States of America, reaffirming our belief in the constitutional right of equal and just treatment of all peoples, DEMAND THE REPEAL of HR 2470, the Medicare Catastrophic Coverage Act of 1988.

Signature	Name	City/State/Zip

Petitition prepared by Seniors Coalition Against the Catastrophic Act.

Please return this copy to: Daniel Hawley, Executive Director, Seniors Coalition Against the Catastrophic Act, 3800 Golf Lane, Las Vegas, Nevada 89108. Telephone: (702) 646-1775

APPENDIX C

SENIORS COALITION AGAINST THE CATASTROPHIC ACT SURVEY

YOUR AGE ________________

CIRCLE YOUR ANSWER

YES NO 1. Do you understand the Medicare Catastrophic Coverage Act?

YES NO 2. Do you understand that the Medicare Catastrophic Coverage Act premiums are MANDATORY?

YES NO 3. Do you understand that if you qualify (age 65), the Supplemental Premium actually is an increase of your INCOME TAX of 15% per person for 1989 (maxiumum $1600 per couple), and that it will increase to 25% per person in 1990 (maximum $1700 per couple)?

YES NO 4. Do you believe that the Supplemental Premium is unconstitutional?

YES NO 5. Do you want the Medicare Catastrophic Coverage Act REPEALED?

YES NO 6. Do you believe that the Act provides enough benefits for the increased costs of the Medicare Part B Premium, the annual increases in the Catastrophic Premiums and the Supplemental Premium?

YES NO 7. If the Catastrophic Act were REPEALED, would you participate in a VOLUNTARY Program administered by the Government covering Long-Term Home Health Care and Long-Term Nursing Home Care?

YES NO 8. Would you prefer a negotiated Private Insurance Plan for Long-Term Home Care and Long-Term Nursing Home Care?

YES NO 9. Are you a member of AARP?

YES NO 10. Does AARP represent your opinion in their support of the Medicare Catastrophic Coverage Act?

YES NO 11. Do you believe that a two-year study by a Presidential Blue Ribbon Committee on Health Care Issues (no members of Congress and no representatives of self-vested interests) would be able to IDENTIFY the actual health care needs of America and PROPOSE an affordable, realistic financing program?

PRINT NAME____

ADDRESS____

PLEASE RETURN IMMEDIATELY TO: SCACA, 3800 GOLF LANE, LAS VEGAS, NV 89108

Optional Information: What do you estimate your 1989 Supplemental Premium will be? ____

SCACA SURVEY

TOTAL COUNT: 7921 DATE: 5-24-89

UESTION #	YES	NO	UNSWERED
1	6139 = 78%	1581 = 20%	2%
2	7564 = 95%	298 = 4%	1%
3	7528 = 95%	295 = 4%	1%
4	7053 = 89%	461 = 6%	5%
5	7676 = 97%	112 = 1%	2%
6	323 = 4%	7137 = 90%	6%
7	4918 = 62%	1727 = 22%	16%
8	5284 = 67%	1391 = 18%	15%
9	6297 = 79%	1534 = 19%	2%
10	407 = 5%	7213 = 91%	4%
11	5437 = 69%	1103 = 14%	17%

AGE	UNDER 65	65 OR OLDER
	1074 = 14%	6847 = 86%

SEX	FEMALE	MALE
	3910 = 49%	4011 = 51%

APPENDIX D

INSTITUTE FOR RESEARCH ON ECONOMICS OF TAXATION REPORT

Who is right? Is the Catastrophic Coverage Act a good deal for Medicare participants? If the Act were not mandatory, would anyone buy this insurance? To answer these questions requires measuring the value of the catastrophic benefits to Medicare enrollees versus what they must pay in premiums and taxes.

Benefits Provided

The Medicare Catastrophic Coverage Act expands Medicare benefits to further limit patient out-of-pocket expenses for hospitals, skilled nursing facilities, hospices, home health care, physician and other outpatient services. The Act also adds new coverage for outpatient prescription drugs. The Act phases in these various benefits over the next five years, beginning with hospital benefits in 1989.

The chart on the preceding page summarizes the benefits according to the year in which they take effect.

The Value of Catastrophic Benefits

The first step in determining whether the Catastrophic Coverage Act is a good deal requires assessing the value of the benefits to Medicare enrollees. According to the Congressional Budget Office (CBO), benefits paid out will amount to approximately $30 billion over the next five fiscal years.[4]

Translating CBO's estimates into calendar years, Table 1 shows the expected payout by type of benefit from 1989 through 1993.[5] By 1993, when all benefit provisions are in effect, Part A catastrophic benefits will account for 24.7 percent of total benefits, Part B for 48.6 percent, and prescription drugs for 26.7 percent.

The Health Care Financing Administration, which administers Medicare, estimates that, in 1989, there will be 32.6 million persons enrolled in Medicare. Only a small percentage, however, will actually receive benefits from the Catastrophic Coverage Act. For example, only 7.2 percent of enrollees are expected to incur large enough hospital expenses to receive benefits under Part A.[6] By law, the Part B copayment cap will be set so that only 7 percent of enrollees will have Part B expenses that exceed the cap, and the drug deductible will be set so that only 16.8 percent of enrollees can exceed it. In other words, after all benefits become available and assuming that there is no overlap among those qualifying for Part A, Part B, or catastrophic drug benefits, roughly 69 percent (100 - 7.2 - 7 - 16.8) will receive no benefits from the Catastrophic Coverage Act in any given year. If there is perfect overlap, about 83.2 percent of enrollees will receive no catastrophic or drug benefits in any given year. Conversely, somewhere between 16.8 percent and 31 percent will receive all the benefits in any one year.

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[4] U.S. Congress, Congressional Budget Office, "The Medicare Catastrophic Coverage Act of 1988," Staff Working Paper, August 1, 1988, Table B-2.

[5] The Federal government's fiscal year runs from October 1st of one year to September 30th of the next year. We translated CBO's fiscal year benefit estimates into calendar years to facilitate comparisons with calendar year premiums and taxes.

[6] CBO, August 1, 1988, Table 7, p. 16. For example, only 6.8 percent of enrollees can expect to be in the hospital two or more times a year and only 0.5 percent can expect an extremely long stay.

Table 1

EXPECTED PAYOUT OF BENEFITS UNDER THE CATASTROPHIC COVERAGE ACT

(in millions of dollars)

	CALENDAR YEAR				
TYPE OF BENEFIT	1989	1990	1991	1992	1993
PART A BENEFITS					
Hospital Benefits	1,294	1,424	1,536	1,669	1,811
Skilled Nursing Facility	359	411	458	500	542
Hospices	1	1	1	1	1
Home Health Care	0	172	185	198	212
PART B BENEFITS					
Copayment Cap	0	2,812	3,432	3,986	4,504
Screening Mammography	0	113	130	142	151
Respite Care	0	85	147	238	377
TOTAL CATASTROPHIC BENEFITS	1,654	5,016	5,889	6,733	7,598
DRUG BENEFITS	0	229	979	1,830	2,771
TOTAL BENEFITS PAID	1,654	5,246	6,868	8,562	10,369

Assuming enrollees do not know whether they will experience catastrophic medical expenditures during the year, the benefits any one Medicare enrollee could expect to receive, on average, as a result of the Catastrophic Coverage Act would be total benefits divided by total number of enrollees. For example, in 1989, the average benefit would be $50.74 ($1,654 million in benefits/32.6 million enrollees). Of course, actual benefits received by any particular beneficiary could be many times the average for all enrollees, most of whom will receive no benefits at all in any given year.

APPENDIX E

HEALTH CARE FINANCE ADMINISTRATION DOCUMENT OPTIONS FOR PREVENTING INSOLVENCY OF THE MEDICARE CATASTROPHIC DRUG INSURANCE TRUST FUND

Subject: Options for Preventing Insolvency of the Medicare
Catastrophic Drug Insurance Trust Fund

The HCFA actuaries now predict a deficit in the Catastrophic Drug Insurance Trust Fund in 1991 of almost $500 million. By the end of 1993, if no action is taken, the Trust Fund deficit is estimated to reach [illegible].

While the general level of these estimates is no secret to informed observers, they will become publicly obvious with submission of the 1990 Budget to Congress.

- Our budget submission to OMB displays these numbers. To account for what would happen once the Trust Fund is depleted, the submission assumes we would hold claims until more money was available. The resulting backlog of claims would quickly become substantial.
- While this assumption fills the need for logical consistency in the budget, if it remains in the budget sent to Congress in January we will be open to questions and possible embarrassment regarding our policy stance.

While we may or may not wish to seek legislation to remedy the problem at this time, we need to consider what our policy should be in case a solution is needed quickly.

Congressional Interest

While Congress has given the Secretary very little room for movement in this area, it is definitely alert to the potential problem. Congress has mandated that we report on drug usage by Medicare beneficiaries in May and November of 1989 and 1990 and in May of each following year. Congress also required the Secretary report by April 1, 1989, on expenses of Medicare beneficiaries for prescription drugs using data from the 1987 National Medical Expenditure Survey (NMES) (which may be delayed). CBO then has 60 days to revise its drug outlay estimates.

Options to Prevent Insolvency

The Medicare Catastrophic Coverage Act sets virtually all of the financial parameters relating to the drug benefit in the first few years and gives the Secretary very little authority to address the problem of insolvency. Attached is an option paper that explores possible legislative solutions to these financial problems. Three options are presented:

- A "premium strategy," which relies on increased premiums, but makes no changes in coinsurance and deductibles.
- A "deductible strategy," which increases deductibles and coinsurance but does not change premiums.
- A "mixed strategy," which would change all three.

Timing of Proposal

We must also decide when we should advance a proposal. We see three distinct possibilities:

- o We could advance a proposal now that could eventually become part of the 1990 budget submission to Congress.
- o We could defer until next summer, after more up-to-date survey data becomes available.
- o We could wait until 1991, after the benefit has been fully implemented and information based on operation of the program is available.

Submitting a proposal now allows us to "seize the high ground" by advancing a solution at the same time we are revealing the problem. This strategy would make it clear that we take the problem seriously and are prepared to deal with it, rather than hope more information will cause it to go away. It would give us more influence over the terms of the Congressional debate, and would also dramatize the magnitude of the problem, which may help make Congress more cautious as it considers other possible program expansions.

Alternatively, delaying submission of a proposal until more recent data on current utilization of outpatient drugs becomes available would give more credibility to our estimates. In particular, we could confirm the assumptions underlying our estimates about utilization of outpatient drugs with data from NMES. NCHSR is currently working on compiling the NMES results: NCHSR has recently informed us that we should not expect the results to be available until April at the earliest. The actuaries do not believe it likely, however, that the NMES data will indicate the need for substantial changes in our assumptions.

FINANCING THE MEDICARE CATASTROPHIC PRESCRIPTION DRUG BENEFIT

OPTIONS PAPER

According to HCFA actuarial estimates, the statutorily-mandated supplemental and flat premiums do not provide sufficient income to pay for the new Medicare prescription drug benefits. At the end of 1991, the Catastrophic Drug Trust Fund will have a deficit of almost $500 million, and in 1992 and 1993, if no action is taken, the Trust Fund deficit will increase to over $2.5 billion and $4.5 billion, respectively. The Secretary, however, does not have authority to make any changes to prevent the Trust Fund's insolvency until 1993.

The following paper summarizes the major facets of the prescription drug benefit, outlines the financial problems, and presents several options for solving these problems.

BACKGROUND

Coverage: The Catastrophic Coverage Act provides for coverage of outpatient prescription drugs, biological products, and insulin under Part B of Medicare. Coverage of drugs will be phased in gradually.

On January 1, 1990, Medicare will begin to cover immunosuppressive drugs beyond the current limitation of one year following a transplant. This coverage will be provided irrespective of whether the transplant was covered by Medicare. On January 1, 1990, Medicare will also begin paying for intravenous (IV) drugs in the home setting. On January 1, 1991, coverage for all other outpatient prescription drugs, biologicals, and insulin will begin.

Secretarial Authority: The premiums, the deductible, and the coinsurance are all set by statute through 1993. It is not until 1993 that the Secretary has the authority to take any action to reduce outlays. At this time, however, the Secretary is prohibited from reducing outlays by implementing a formulary, increasing coinsurance above that of the previous year, or changing the methodology for determining whether an individual has met the drug deductible. The Secretary may do such things as increase the amount of the deductible, maintain coinsurance at the previous year's level, and modify the payment methodology. No changes may be made to premium rates.

Coinsurance: Coinsurance for home IV drugs and the current immunosuppressive drug benefit (the first year of drug therapy following a Medicare-covered transplant) is set permanently at 20 percent. Coinsurance for the new immunosuppressive drug benefit

The last approach, waiting until 1991, is risky given our current estimates. If the actuaries' scenario unfolds, the trust fund will be in deficit by almost $500 million by the end of 1991. Actual claims data to support this estimate, though, would probably not be available until very late in that year. At that time, options similar to those presented here would have to be considered, but the amount of time for decision making by the Administration and the Congress would be extremely compressed.

Regardless of the timing chosen for advancing a proposal on financing drugs, we believe that HCFA should begin now to develop a proposal. It is highly probable that something will need to be done, and it would be prudent to begin to reach consensus on an appropriate approach.

Additional Problems

In addition to the problems of insolvency, on the last two pages of the attached paper we call to your attention three separate problems related to financing the drug benefit for which we are recommending legislative changes (see page 12). These proposals would: preclude a cash flow deficiency in 1990; improve the methodology for financing the benefit in the out-years; and reform the prescription drug payment methodology in such a way that would avert the potential for excessive reimbursement under the statute. The issue of 1990 cash flow needs to be addressed as part of the FY 1990 budget. The other two provisions would be proposed in conjunction with legislation to assure Trust Fund solvency.

We would like to receive your comments on the following: the option that you prefer for preventing the insolvency of the Trust Fund, the appropriate timing for submitting a legislative proposal, and whether you agree with the need for the three related proposals presented on pages 12 and 13. I would appreciate receiving your response by COB Monday, November 14. If you have any questions please contact Anne Scott at 245-0001. Thank you for your assistance.

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Coinsurance: Coinsurance for home IV drugs and the current immunosuppressive drug benefit (the first year of drug therapy following a Medicare-covered transplant) is set permanently at 20 percent. Coinsurance for the new immunosuppressive drug benefit (immunosuppressives used more than one year after a Medicare-covered transplant or used at any time after a non-Medicare-covered transplant) and other covered prescription drugs is set at 50 percent in 1990 and 1991, 40 percent in 1992, and 20 percent thereafter.

Deductible: Prescription drug coverage is subject to a deductible specified by the statute: $550 in 1990, $600 in 1991, and $652 in 1992. In 1993 and beyond, the deductible will be set by the Secretary at a level that will allow 16.8 percent of beneficiaries to receive the benefit in each year.

The deductible will not apply to the current immunosuppressive drug benefit furnished to individuals within one year after a transplant or to home IV drug therapy initiated while an individual was an inpatient in a hospital.

Financing: These benefits will be financed by a combination of flat Part B premiums and supplemental premiums. The monthly flat premium for drugs is specified in the statute:

1991....	$1.94
1992....	$2.45
1993....	$3.02

Premiums after 1993 are determined in accordance with a rigid statutory formula on the basis of previous outlays and past premium liability.

Annual supplemental premiums are imposed on individuals who are eligible for Medicare for more than 6 months in a calendar year. Each individual will be required to pay a certain amount for each $150 of Federal income tax liability. This premium (in combination with the catastrophic supplemental premium) is subject to a maximum annual limitation:

	Supplemental Drug Premium Rate (per $150 of Tax Liability)	Annual Maximum Premium (When Combined With Catastrophic Premium)
1990........	$10.36	$850
1991........	$ 8.83	$900
1992........	$ 9.95	$950
1993........	$12.45	$1,050

For years after 1993, supplemental premium rates will be increased in accordance with a rigid statutory formula. The combined drug and catastrophic supplemental premium rate each year may not increase by more than $1.50. If this limitation must be applied, the flat premiums will be increased to make up the difference.

Contingency Margins

In theory, the financing of the Drug Insurance Trust Fund has been structured to provide for a contingency margin each year. This margin is built into the statutorily-set premiums, and beginning in 1994, the Secretary is required to make an adjustment to the premium to the extent that the contingency margin was not achieved in the second preceding year. Contingency margins are high in the early years and gradually decrease to 20 percent, as follows:

Contingency Margins

1991...............	100%
1992...............	75%
1993...............	50%
1994...............	25%
1995...............	25%
1996 & Thereafter..	20%

Payment Methodology

Medicare will reimburse for drugs using the following payment rules:

Multiple Source Drugs - The lower of: (1) the actual charge; or (2) the median of average wholesale prices plus an administrative allowance. The average wholesale price is to be based on published average wholesale (or direct) prices or on a biannual survey done by the Secretary.

Single Source or Restrictive Prescriptions - The lower of: (1) the actual charge; (2) the 90th percentile of actual charges from a previous period; or (3) the average wholesale price or comparable direct price (determined from a biannual survey) plus an administrative allowance.

Biannual surveys are to be based on wholesale or comparable direct prices (excluding discounts) obtained from a representative sample of direct sellers, wholesalers, or pharmacies.

The administrative allowance is $4.50 in 1990 and 1991 for participating pharmacies and $2.50 for other pharmacies, and is increased by the GNP deflator in the out-years.

Reports to Congress and Publication of Regulations

The Secretary is required to report to Congress annually on the drug benefit. The reports in 1992 and 1993 must include a determination of whether outlays and receipts for the next year will provide for the "minimum contingency margin" required by statute. (The "minimum" required is 50 percent in 1993 and 25 percent in 1994.) If not, the Secretary is required to publish a proposed regulation by May 1 making changes that will reduce outlays by an appropriate amount to provide the required contingency margin. A final regulation must be published during the last three days of September and is effective for only one year beginning on Jan. 1. (No such changes are permitted before 1993.)

PROBLEM

Cost Estimates

CBO and HCFA estimates of the cost of the prescription drug program diverge widely. The premiums that are set in statute were based on CBO estimates. HCFA, however, has estimated considerably higher outlays for the program. Whereas CBO calculations indicate that 16.8 percent of Medicare beneficiaries will meet the drug deductible and use the benefit in 1991 and 1992, HCFA has estimated that 25 percent of beneficiaries will receive benefits in both 1991 and 1992.

According to the latest estimates from HCFA's actuaries, not only will the program come nowhere near to meeting the required contingency margins but income will be insufficient to provide the necessary benefits. The table below summarizes expected income and outlays of the Drug Insurance Trust Fund on a calendar year basis.

Catastrophic Drug Program
Outlays and Income ($ in millions)

	CY 1990	CY 1991	CY 1992	CY 1993
Cash Income..................	$404	$2,388	$2,475	$3,039
Cash Outlays.................	239	3,037	4,518	4,997
Cash Surplus (Deficit)......	165	(649)	(2,043)	(1,958)
Trust Fund Balance..........	165	(484)	(2,527)	(4,485)
Contingency Margin (Trust Fund balance as % of current year outlays)......	69%	-16%	-56%	-90%

Under this scenario, beginning in 1991, the Drug Trust Fund will run out of money. HCFA will be forced to hold claims and pay interest on such claims until more premium income becomes available. Over time, the backlog of claims will grow to enormous proportions.

1993 is the first year that the Secretary has authority to make regulatory changes in the drug program. At that time, the Trust Fund will face a deficit of -$2.5 billion from the previous year and will anticipate an additional shortfall in 1993 of $2.0 billion.

Legislative solutions to the financial problems of the Drug Insurance Trust Fund include such things as: increasing premiums, reducing benefits by raising the deductible, and increasing the coinsurance.* The following pages explore three options that would deal with these problems.

SUMMARY OF OPTIONS

The following is a summary of the impact of the three options on premiums, deductible, and coinsurance:

IMPACT OF OPTION ON:	(1) PREMIUM STRATEGY	(2) MIXED STRATEGY	(3) DEDUCTIBLE STRATEGY
Flat Premium (1990)........	No Change (0 Premium)	$1 Premium	No Change (0 Premium)
Flat Premium (1991-1993)...	3-Year Average Increase of 86%	3-Year Average Increase of 17%	No Change
Supplemental Premium (1991-1993)...	3-Year Average Increase of 87%	3-Year Average Increase of 20%	No Change
Deductible (1991-1992)...	No Change	2-Year Average Increase of 35%	2-Yr. Average Increase of 68%
Coinsurance.....	No Change	Increase from 20% to 40% in 1993	Increase from 20% to 40% in 1993

* Note that under all options the contingency levels would be reduced from the higher levels legislated by Congress to levels that the actuaries believe are sufficient (50% in 1991, 40% in 1992, and 30% in 1993).

Option 1 - Premium Strategy

OPTION: Increase the flat and supplemental premium rates by an amount sufficient to eliminate the estimated deficit and provide an adequate contingency reserve.

Under this option, premiums would go up substantially. The flat premium would increase from $1.94 to $5.21 per month in 1991 and by an average of 86% annually over the 3-year period between 1991 and 1993. The amount of supplemental premium income required would also increase by an average of 87% over this same 3-year period.

PROs:

- Would not reduce the scope of the benefit. The amount of the deductible would be maintained, and the same percentage of beneficiaries (25% in 1991 and 1992; 16.8% in 1993 and subsequent years) would receive the benefit.

CONs:

- Would increase the already substantial financial burden that the Catastrophic Care Act places on beneficiaries. Both flat and supplemental premium income would more than double in 1991.
- Would probably not be acceptable to OMB, which argued strongly during deliberations on the Medicare Catastrophic Coverage Act that the drug program should be constrained within the premium level now in the law.

Under this option, the increases that would be required in the flat premium and in supplemental premium income are shown below. Note that the relative contribution of supplemental and flat premiums to Trust Fund income would be maintained at the current 63/37 ratio.

Prescription Drug Flat Premium

	Current	Increase	New Premium
1990.........	----	----	----
1991.........	$1.94	$3.27	$5.01
1992.........	$2.45	$1.04	$3.49
1993.........	$3.02	$1.44	$4.46

Prescription Drug Supplemental Premium Income ($ in millions)

	Current	Increase	New Total
1990.........	$1,585	----	$1,585
1991.........	$1,394	$2,219	$3,613
1992.........	$1,625	$ 828	$2,453
1993.........	$2,115	$1,072	$3,187

(Although the actuaries are able to provide an estimate of additional income needed, only the Department of Treasury can determine what the actual increase in the supplemental premium rate and/or annual maximum liability would be.)

Option 2 - Deductible Strategy

OPTIONS:

- o Increase the deductible to the level necessary to make the Trust Fund solvent and to provide for an adequate contingency margin.
- o Maintain coinsurance at 40% (rather than 20%) in 1993.

This option would require large increases in the deductible. In 1991, the deductible would be raised 68% from $600 to $1,005. Only 11.9% of beneficiaries would receive the benefit at this level.

PROs:

- o Would not expand the program beyond the premium levels set in statute.

CONs:

- o A significantly smaller number of beneficiaries will receive the benefit.
- o The imposition of such a large deductible in combination with premiums (which for some individuals will be very substantial) will not be perceived favorably.

Under this option, the deductible required would be as follows:

	Deductible		
	Current	Increase	New Deductible
1990..........	550	----	550
1991..........	600	405	1,005
1992.........	652	443	1,095
1993.........	960	85	1,045

In addition, the percentage of beneficiaries receiving the benefit would decrease as is shown below:

	% of Enrollees Receiving Benefit		
	Current	Decrease	New Percent
1991.........	25.0%	-13.1%	11.9%
1992.........	24.8%	-13.1%	11.7%
1993.........	16.8%	-2.1%	14.7%

Option 3 - Mixed Strategy

OPTION:

- Increase the deductible so that only 16.8 percent of the beneficiaries will receive the benefit.
- Maintain coinsurance in 1993 at 40% (rather than 20%).
- Add a flat premium of $1 in 1990.
- Raise both the supplemental and flat premiums in 1991-1993 as necessary to eliminate the remaining deficit and provide an adequate contingency margin.

This option would require a much smaller increase in premiums than under option #1. The flat premium would increase from $1.94 to $2.45 in 1991, and would experience a 3-year average increase of 17% between 1991 and 1993. Supplemental premium income required would go up by an average of 20% over this 3-year period. The deductible in 1991 would go up by 36% from $600 to $815.

PROs:

- Covers the percentage of beneficiaries (16.8%) envisioned by Congress. (CBO estimates that the deductible set in statute for 1991 and 1992 will yield this percentage. HCFA, however, estimates that under current law 25% of beneficiaries will receive the benefit in these years.)
- Represents a balanced approach toward preventing the insolvency of the Trust Fund. A combination of increasing the deductible, increasing coinsurance, and raising premiums avert the necessity of taking any one extreme measure and of placing an onerous financial burden on any one group of beneficiaries.

CONs:

- A smaller number of beneficiaries will receive the benefit in 1991 and 1992 than under current law.
- The imposition of such a large deductible in combination with premiums (which for some individuals will be very substantial) will not be perceived favorably.
- Would expand the program beyond the premium levels set in statute.

Under such a scenario, the increases required in the flat premium and in supplemental premium income are shown below:

	Prescription Drug Flat Premium		
	Current	Increase	New Premium
1990..........	----	$1.00	$1.00
1991..........	$1.94	$ .51	$2.45
1992..........	$2.45	$ .99	$3.44
1993..........	$3.02	-$ .41	$2.61

	Supplemental Premium Income ($ in millions)		
	Current	Increase	New Total
1990..........	$1,585	----	$1,585
1991..........	$1,394	$ 306	$1,700
1992..........	$1,625	$ 794	$2,419
1993..........	$2,115	-$ 247	$1,868

To cover 16.8% of beneficiaries, the deductible would be increased to the following levels:

	Deductible		
	Current	Increase	New Deductible
1990..........	550	----	550
1991..........	600	215	815
1992..........	652	228	880
1993..........	960	----	960

ADDITIONAL LEGISLATIVE PROPOSALS

In addition to the problem of insolvency outlined above, three additional problems related to financing the drug benefit that need to be addressed are discussed below. They would all require legislation and could be pursued regardless of the strategy adopted to address the insolvency problem.

Even if a decision is made not to address the financial solvency of the drug benefit in the FY 1990 budget, we recommend that the first proposal be included in the 1990 budget since it is needed to fix a problem occurring at the beginning of 1990.

(1) 1990 Cash Flow - In 1990, although there will be a cash surplus at the end of the year, it appears that there may be a cash flow problem in the early months of the year. We propose solving this problem by requesting legislative authority for one year only (1990) to borrow money from the Part B Trust Fund to pay the drug benefits and administrative expenses and start-up costs until such time as sufficient premiums can be collected. At that time, the money would be repaid to the Part B Trust Fund with interest.

(2) Out-Years - Beginning in 1994, the statute has established a rigid and complex retrospective formula for calculating the flat and supplemental premiums. This formula will result in erratic increases in the premiums and the accumulation of excessive revenue in some years.

Instead, we propose using a methodology for calculating premiums similar to that currently used under Part B. The Secretary would have the authority to establish the premiums each year based on the estimated actuarial value of benefits in the following year. A contingency margin of 30 percent would be provided for, and the split between supplemental and flat premiums would be maintained at 63/37.

The Part B premium methodology has proven to be effective over the 20 year history of the program. It would be considerably simpler than the procedure that has been legislated and would preclude the irregular premium growth that the statutory methodology would cause.

It is possible that some objection may be raised about giving the Executive Branch the authority to establish tax rates. (The Secretary would be required to estimate income needed from supplemental premiums in the following year, and the Treasury Department would calculate the actual premiums.) A way of mitigating these objections might be to require the Secretaries of HHS and Treasury to issue a proposed and final notice in the Federal Register each year to announce the tax rates. The final rate would then go into effect unless Congress took action. This would give Congress the opportunity to review the rates in advance.

(3) Reimbursement - We also propose replacing the reimbursement methodology established by the statute. For single-source drugs, payment could be based on direct price or, if direct price is not available, a specified percentage of average wholesale price (e.g., 95%). For multiple-source drugs, alternative options should be explored, such as basing payment on 150% of the least costly generic product.

Although there is general agreement within the agency that the reimbursement methodology provided in statute is too generous, these proposed changes would precipitate tremendous opposition from the drug industry. In addition, they would not be scored by the actuaries as generating any savings. (Given the overall uncertainty in estimating the drug benefit, the HCFA actuaries currently evaluate the impact of any change in the payment methodology as if it were an estimating error.) Regardless of the scoring question, though, we believe that the proposed reimbursement methodology would reduce program outlays and is a more equitable methodology than that currently in statute.

PREPARED STATEMENT OF SENATOR JOHN HEINZ

My constituents, in writing to me about the financing of the Medicare Catastrophic Coverage Act, have raised many legitimate issues. These include concerns over the distribution of the financing. Also, some people feel that the program should be voluntary. Others who have private employer plans are bothered by duplicate coverage. These are legitimate issues we should examine.

The cost and revenues of the bill have been a problem since Senator Mitchell and I were deeply involved in conferencing the Catastrophic legislation, and since I originally authored and offered the prescription drug amendment. Since the beginning there have been wide disparities between the Congressional Budget Office's (CBO) and the Administration's cost estimates—at times estimates were 200-400 percent apart.

Today, we will examine the accuracy of our original cost calculations in the light of possible surpluses. There is some irony that a Congress regularly under the gun for running budgets in the red now faces public firing squads for potentially running one in the black.

Senator Moynihan has the right solution: we must stop using the surplus from Social Security accounts to pay for government deficit spending. I'd like to see all of the Social Security accounts taken off-budget as soon as possible. But, I appreciate the $50-$60 billion deficit problem that this raises this year. The Catastrophic trust funds, perhaps together with Medicare, should be able taken off immediately. I believe we need to take the social insurance programs off-budget so they can be run efficiently and free of politics—without leaving the elderly wondering if we are doing something unseemly.

PREPARED STATEMENT OF JOHN L. HILDRETH

I am John Hildreth, Director of the Southwest Regional Office of Consumers Union.[1] We appreciate the opportunity to testify today before the Senate Finance Committee on the Medicare Supplement Insurance Market.

For many years, Consumers Union, through its offices in Texas, California, and the District of Columbia has advocated for protections for elderly consumers from abuses in the Medigap market. Additionally, Consumer Reports, a publication of Consumers Union, has investigated and rated Medigap policies in 1976, 1984, and in the June 1989 issue.

I want to share with the Committee the nature and magnitude of the problems in Texas, how regulators have failed to protect the elderly, and why Consumers Union believes aggressive steps are needed now to correct these abuses.

The importance of the Medigap market is not in question. In Texas there are an estimated 1.7 million people eligible for Medicare, and therefore potential buyers of Medigap insurance. In 1987, elderly Texans paid more than $200 million for Medigap policies. In addition, there are more than 120,000 agents who can sell almost 600 different approved Medigap policies in the state.

Present regulation of the Medigap market in Texas has been a failure. Although the State Board of Insurance (FBI) has been aware of the problems in the Medigap market, it has yet to take decisive action to correct them. Consumers Union supported legislation which would have given Texas' insurance regulators a mandate to end the abuses in the Medigap industry.

The size of the market and the ineffectiveness of insurance regulation has led to numerous problems for elderly consumers in Texas: (1) there is widespread misunderstanding about Medigap policy provisions; (2) many elderly consumers rely on the advice of insurance agents who, intentionally or otherwise, mislead elderly consumers in their purchase of Medigap policies; (3) many elderly send their names to lead developers for information about Medicare, who in turn sell these names to Medigap agents; (4) and the policies sold are not a fair value because Texas and most other states do not enforce the minimum loss-ratio targets enacted by the Baucus Amendment almost 10 years ago.

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[1] Consumers Union of U.S. Inc., is a non-profit membership organization chartered in 1936 under the laws of the state of New York to provide information, education, and counsel about consumer goods and services and the management of the family income. Consumers Union's income is derived solely from the sale of *Consumer Reports,* its other publications and films. Expenses of occasional public service may be met, in part, by non-restrictive, non-commercial contributions, grants, and fees. In addition to reports on Consumers Union's own product testing, *Consumer Reports* with over 3.5 million paid circulation, regularly carries articles on health, product safety, marketplace economics, and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

ASSURING THAT MEDIGAP POLICIES ARE A FAIR VALUE

In Texas, because the premium rates of Medigap insurance are not regulated by the State Board of Insurance, the only way consumers are assured that Medigap policies are a fair value is their reliance on the enforcement of "loss-ratio" regulations. Loss-ratios measure the proportion of total premiums taken in by a policy that are paid out as benefits to policyholders. Loss-ratios, in general, measure the value of a Medigap policy; policies with high loss-ratios are a better value than those with low loss-ratios. According to the 1986 and 1987 reports issued by the State Board, well over one-half of the Medigap policies issued in Texas failed to meet the minimum targets. According to a recent General Accounting Office report on national statistics for loss-ratio compliance, the industry nationwide has performed dismally. [1987 Loss-Ratios of Selected Medigap Insurance Policies, General Accounting Office, May 5, 1989]

While Texas adopted the Baucus standards for minimum loss-ratio targets nearly 10 years ago, the Board claimed a lack of legislative authority to roll-back rates. Effectively, the Board was hoping the industry would voluntarily comply with the minimum standards. Unfortunately, the industry has not. A bill which was defeated in Texas House would have required the State Board to roll-back rates or pay dividends to policyholders for policies that do not meet the minimum loss-ratio requirements.

LEAD CARDS AND MEDIGAP ADVERTISING

Sharp sales and advertising practices dominate the marketing of Medigap policies. Texas has the regrettable reputation of being home to many of the nation's lead developers. Lead developers generate "leads," or contact lists, used by insurance agents to sell policies to clients. Generally, Medigap lead developers put out advertisements which offer information about Medicare. These ads may appear to be from the government, or a consumer organization, or may have an official sounding return address in Washington, D.C. Often the D.C. address is only a drop box for a lead developer in Dallas. The lists, including names, addresses, and telephone numbers of elderly consumers, are sold to Medigap agents who use the lists to sell elderly consumers Medigap policies. Until recently, the State Board has done little to stop the practice of the misleading advertisements used to generate leads.

Texas regulators have also been slow to act to end other deceptive practices in Medigap advertising. Consumers Union's Southwest Regional Office collected numerous Medigap ads from newspapers and mailings. These advertisements are a testament to the flood of promotional material sent to seniors. The ads also show the scare tactics employed to increase sales of Medigap policies. [See Attachment] Although the Board was aware of these misleading ads, they claimed they could do little to stop them. The problem is this: often an advertisement is not put out by an insurance agent or company, but rather by a lead developer or some other entity. Because the company publishing the ad is not a licensed insurer, the Board claimed it had no regulatory authority. Years of inaction by the Board gave unscrupulous advertisers and lead developers the impression that insurance regulators in Texas could not, or would not, act to stop deceptive advertisements. As a consequence, Medigap advertising and the lead developer industry expanded in Texas. Because Texas is home to many of these companies and does little to stop the unscrupulous ones, other states across the nation are adversely affected.

The bill which was defeated in the Texas House would have required pre-approval of Medigap advertisements, and would have required Medigap advertisements to give the name of a licensed insurance agent or company. The legislation would have allowed the Board to prosecute those companies sponsoring deceptive advertisements.

MEDIGAP AGENTS AND SALES PRACTICES

Many of the problems associated with the Medigap market happen because of agent misrepresentations of abusive sales practices. Currently, agent licensing and educational requirements are quite lax. The State Board has begun to change the procedures for testing agents.

However, the underlying problem of aggressive sales practices is the agent commission structure itself. Medigap agents receive much higher commissions for new sales than for renewals. Therefore, agents have an incentive to encourage the elderly consumer to switch, or "twist," old policies for new ones. The agent gets a higher commission and the consumer is subject to a waiting period of up to six months. In order to protect the elderly from these practices, the defeated bill would have credited a consumer for any previously satisfied waiting period. Further, the bill, to a limited degree, would have required level commissions for Medigap agents.

MISUNDERSTANDING POLICIES AND DUPLICATE COVERAGE

Fundamental to all the problems in the Medigap market is the widespread lack of understanding of Medigap policies. In order for a free market to operate correctly, consumers must make informed decisions. However, Medigap consumers are not informed consumers.

There are about 600 different Medigap policies approved for sale in Texas. The policies vary from one another in so many ways, it is virtually impossible to compare the value offered by various policies. Sadly, companies succeed in Texas not through selling fair-priced and well serviced policies, but through aggressive and misleading advertising and sales practices.

The bill would have required the implementation of standardized policies with three different levels of coverage. Standardized policies are promulgated by insurance regulators. They specify a limited number of policy forms to reduce consumer confusion. No insurer selling a Medigap policy may sell one that differs from one of the standard forms. Standardization permits consumers to compare policies side-by-side, since the policy offered by one insurer is identical to the policy offered by another. Standardization is the only way to assure that elderly consumers are able to make informed choices about Medigap policy purchases, and are not at the mercy of the agent selling the policy. The West Coast office of Consumers Union also supported legislation establishing standardized policies. They plan to petition the California Insurance Department to implement the policies according to the legislation.

THE IMPORTANCE OF A REGULATORY FRAMEWORK

The growing impression of consumers is that the primary function of insurance regulation is to protect the insurance industry. In Texas, the insurance industry stopped a Medicare supplement insurance reform bill in a House Committee after it had received overwhelming approval in the Senate. The influence of the industry in insurance regulatory decisions in Texas and across the nation is evident. Also evident, in the increasing calls for insurance reform, is consumer frustration with the ability of their government to effectively regulate insurance.

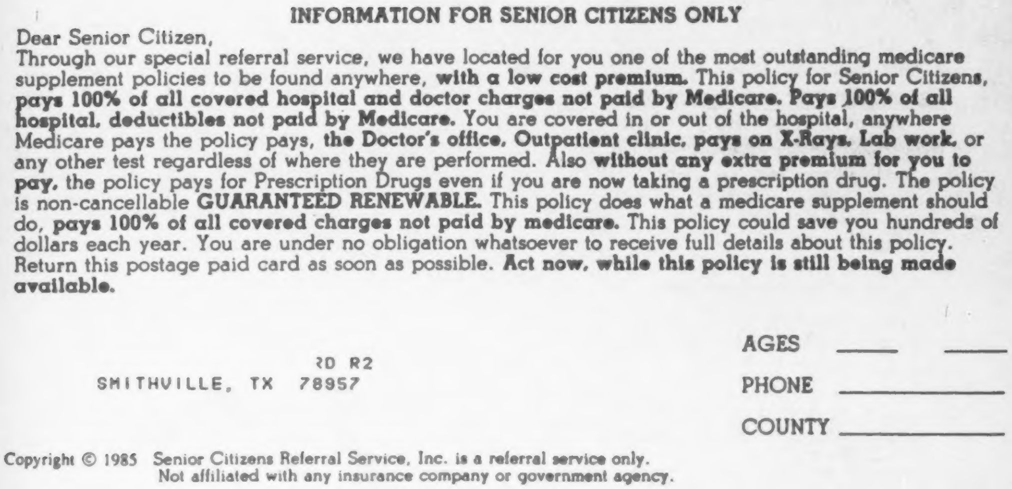
Consumers in Texas need meaningful Medigap insurance reforms. Consumers in Texas, like consumers throughout the country, need Congress to take steps to improve the performance of this market.

Thank you for allowing Consumers Union to testify today.

ATTACHMENT

CONSUMERS UNION TESTIMONY

APRIL 26, 1989



INFORMATION FOR SENIOR CITIZENS ONLY

Dear Senior Citizen,

Through our special referral service, we have located for you one of the most outstanding medicare supplement policies to be found anywhere, **with a low cost premium.** This policy for Senior Citizens, **pays 100% of all covered hospital and doctor charges not paid by Medicare. Pays 100% of all hospital, deductibles not paid by Medicare.** You are covered in or out of the hospital, anywhere Medicare pays the policy pays, **the Doctor's office, Outpatient clinic, pays on X-Rays, Lab work,** or any other test regardless of where they are performed. Also **without any extra premium for you to pay,** the policy pays for Prescription Drugs even if you are now taking a prescription drug. The policy is non-cancellable **GUARANTEED RENEWABLE.** This policy does what a medicare supplement should do, **pays 100% of all covered charges not paid by medicare.** This policy could save you hundreds of dollars each year. You are under no obligation whatsoever to receive full details about this policy. Return this postage paid card as soon as possible. **Act now, while this policy is still being made available.**

RD R2
SMITHVILLE, TX 78957

AGES ______ ______

PHONE ____________

COUNTY ____________

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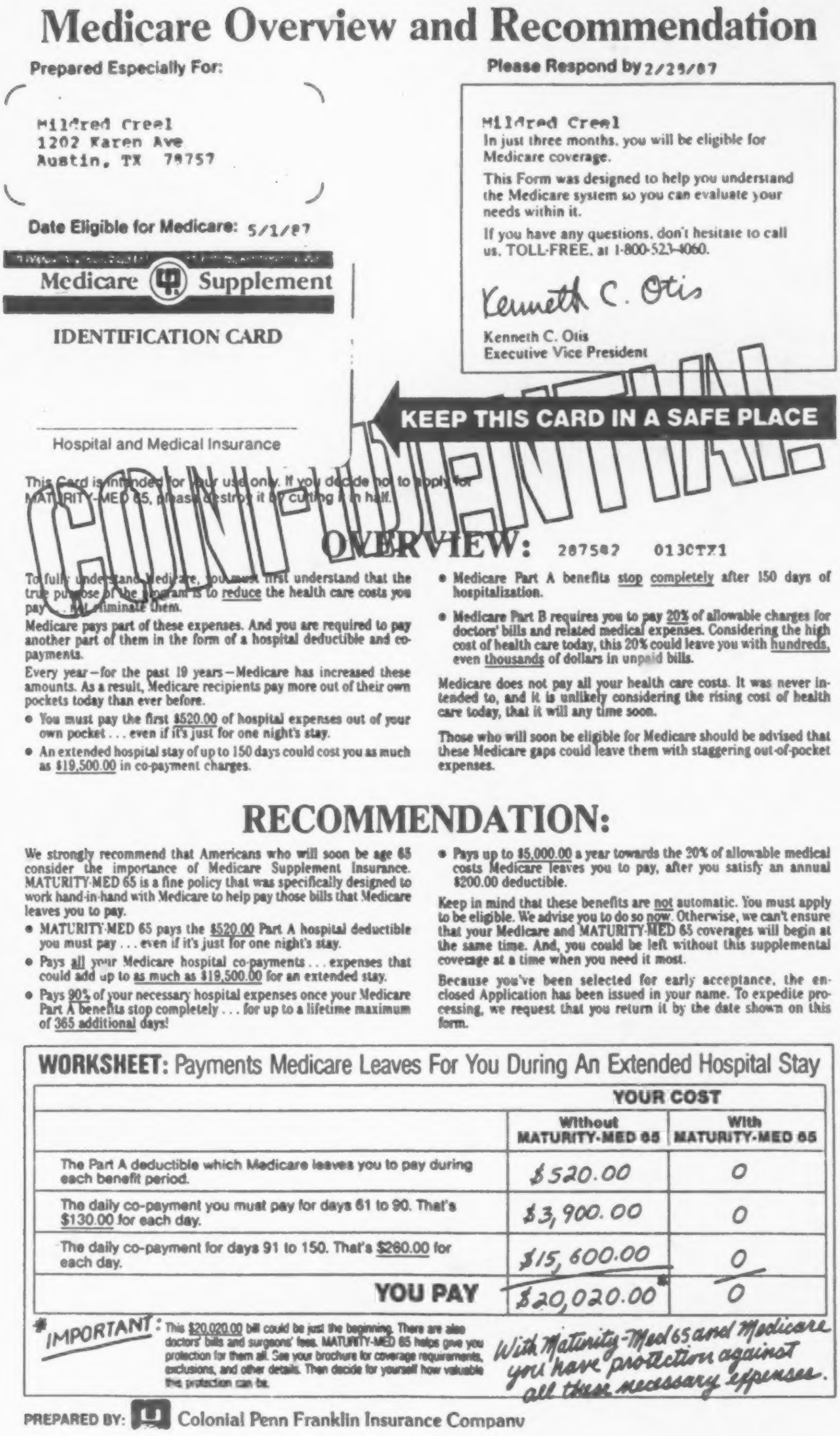
Not affiliated with any insurance company or government agency.



Medicare Overview and Recommendation

Prepared Especially For:

Mildred Creel
1202 Karen Ave
Austin, TX 78757

Date Eligible for Medicare: 5/1/87

Medicare Supplement

IDENTIFICATION CARD

Hospital and Medical Insurance

This Card is intended for your use only. If you decide not to apply for MATURITY-MED 65, please destroy it by cutting it in half.

Please Respond by 2/25/87

Mildred Creel
In just three months, you will be eligible for Medicare coverage.

This Form was designed to help you understand the Medicare system so you can evaluate your needs within it.

If you have any questions, don't hesitate to call us, TOLL-FREE, at 1-800-523-4060.

Kenneth C. Otis

Kenneth C. Otis
Executive Vice President

KEEP THIS CARD IN A SAFE PLACE

CONFIDENTIAL

OVERVIEW:

287582 013CTZ1

To fully understand Medicare, you must first understand that the true purpose of the program is to reduce the health care costs you pay . . . not eliminate them.

Medicare pays part of these expenses. And you are required to pay another part of them in the form of a hospital deductible and co-payments.

Every year—for the past 19 years—Medicare has increased these amounts. As a result, Medicare recipients pay more out of their own pockets today than ever before.

- You must pay the first $520.00 of hospital expenses out of your own pocket . . . even if it's just for one night's stay.
- An extended hospital stay of up to 150 days could cost you as much as $19,500.00 in co-payment charges.
- Medicare Part A benefits stop completely after 150 days of hospitalization.
- Medicare Part B requires you to pay 20% of allowable charges for doctors' bills and related medical expenses. Considering the high cost of health care today, this 20% could leave you with hundreds, even thousands of dollars in unpaid bills.

Medicare does not pay all your health care costs. It was never intended to, and it is unlikely considering the rising cost of health care today, that it will any time soon.

Those who will soon be eligible for Medicare should be advised that these Medicare gaps could leave them with staggering out-of-pocket expenses.

RECOMMENDATION:

We strongly recommend that Americans who will soon be age 65 consider the importance of Medicare Supplement Insurance. MATURITY-MED 65 is a fine policy that was specifically designed to work hand-in-hand with Medicare to help pay those bills that Medicare leaves you to pay.

- MATURITY-MED 65 pays the $520.00 Part A hospital deductible you must pay . . . even if it's just for one night's stay.
- Pays all your Medicare hospital co-payments . . . expenses that could add up to as much as $19,500.00 for an extended stay.
- Pays 90% of your necessary hospital expenses once your Medicare Part A benefits stop completely . . . for up to a lifetime maximum of 365 additional days!
- Pays up to $5,000.00 a year towards the 20% of allowable medical costs Medicare leaves you to pay, after you satisfy an annual $200.00 deductible.

Keep in mind that these benefits are not automatic. You must apply to be eligible. We advise you to do so now. Otherwise, we can't ensure that your Medicare and MATURITY-MED 65 coverages will begin at the same time. And, you could be left without this supplemental coverage at a time when you need it most.

Because you've been selected for early acceptance, the enclosed Application has been issued in your name. To expedite processing, we request that you return it by the date shown on this form.

WORKSHEET: Payments Medicare Leaves For You During An Extended Hospital Stay

	YOUR COST	
	Without MATURITY-MED 65	With MATURITY-MED 65
The Part A deductible which Medicare leaves you to pay during each benefit period.	$520.00	0
The daily co-payment you must pay for days 61 to 90. That's $130.00 for each day.	$3,900.00	0
The daily co-payment for days 91 to 150. That's $260.00 for each day.	$15,600.00	0
YOU PAY	$20,020.00*	0

*IMPORTANT: This $20,020.00 bill could be just the beginning. There are also doctors' bills and surgeons' fees. MATURITY-MED 65 helps give you protection for them all. See your brochure for coverage requirements, exclusions, and other details. Then decide for yourself how valuable this protection can be.

With Maturity-Med 65 and Medicare you have protection against all these necessary expenses.

PREPARED BY: Colonial Penn Franklin Insurance Company

Senior Citizen Information Center
219 Kennedy Street N.W.
Washington, D.C. 20011

SPECIAL INFORMATION:

Dear Senior Citizen:
Recent Congressional Reports confirm that Medicare has been covering **less** of the cost for medical treatment than ever before. The next several years will see further cuts. A long hospital stay can **wipe out your savings** and put you in **dire financial straits.** Already your **part A deductible** has been **increased to $492.00**. Many **congressional leaders** including, **Rep. Claude Pepper**, are doing their best to stabilize the system.

Recently, in one of our letters we stated, "SOMETHING MUST BE DONE" well,

SOMETHING HAS BEEN DONE

In checking with private Insurance Companies we have found some plans to meet your needs. Plans that pay **100% of hospital charges** and on **all doctors charges in** and **out** of the hospital in excess of those benefits paid under Medicare.

We have found additional plans that might be of interest to you;

1. **Nursing Homes**
2. **Prescription Drugs**
3. **Cancer**
4. **Cash Plans which will pay you $100.00 per day regardless of any other insurance you may have**

All of the above plans are at very inexpensive rates.

Senior Citizens Information Center is trying to find the best coverage at the lowest cost to you and we will continue to do so.

If you are interested in learning about these plans, just fill out the enclosed postage paid card and you will receive information that will be of significant importance to you.

Sincerely,

J. Bridges
INFORMATION CENTER

TEXAS MEDICAL CLAIM SERVICE
8247 Hwy. 80W P.O. Box 12521 (817) 560-2262
Fort Worth, Texas 76121

Dear Senior Texan:

If you have ever had problems with the massive paper work involved in filing health insurance claims and keeping track of payments, we have great news for you!

What if you could have all your Medicare claims and private insurance claims filed for you? What if you had professionals to follow thru and make sure you receive all payments due you?

What would this service be worth to you?

Well, for a *limited time* this service is offered for **$75.00;** not per claim, not per year but for 3 years of claim service! Our studies show this service would be a bargain at 3 times the price for the peace of mind **alone.**

The service is extremely simple. We furnish you with postage paid envelopes, you simply send us the information, we take care of it from there. We maintain a file with copies of all claims and important information. Benefit payments are sent directly to you by Medicare or your insurance company.

Now you can take the burden off you or your loved ones, and for an extremely reasonable cost!. . .$25.00 a year average for the next 3 years!

Texas Medical Claim Service is ready to be of service. Please read the enclosed "fact" sheet and excerpts from letters of some of our satisfied clients.

For this special offer act now! This service has never been offered at this low price before . . . and will never be offered at this price again! Send your check or money order with the enclosed card, today!

Sincerely,

Rita Lauderdale

Rita Lauderdale
Service Director

P.S. Your packet containing all the information and envelopes you need will be sent immediately.

If you have a friend who needs this service but did not receive this offer, just have them send us their name and address, etc. . . . along with their check, and include your name as a reference.

ENDORSED BY

1. National Health and Medical Service
2. United Seniors of America
3. National Health and Medicare Services
4. Senior Citizens Information Center
5. Medical Information Services
6. Medical Insurance Service Group
7. National Consumer Referral Service
8. National Insurance Brokers (Ft. Worth)

Military and Civil Service Welcome!

Receive your claim check FASTER with Automatic Claims Service.

✓ NO CLAIM FORMS
✓ NO PAPER WORK
✓ NO DELAYS

PRESCRIPTION DRUG BENEFITS AVAILABLE

TO FIND OUT HOW YOU CAN HAVE "AUTOMATIC" CLAIM SERVICE, COMPLETE AND SEND THE ATTACHED POSTCARD TODAY. NO POSTAGE NECESSARY.

MEDICARE CLAIMS SERVICE

8760A Research Blvd.
Austin, Texas 78758-9982

Please see that I receive additional information about Automatic Claim Service.

☐ YES I AM INTERESTED IN HAVING PRESCRIPTION DRUG BENEFITS.

☐ NO I AM NOT INTERESTED IN HAVING PRESCRIPTION DRUG BENEFITS.

Name ______________________ Age ________

Address ______________________________

City ______________________ State ________

County ______________________ Zip ________

Phone ______________________________

P.S. Area Code and Phone # insures proper information routing.

CHRISTIAN
BROTHERHOOD

530 Bedford Rd. Bedford, Texas 76022 817/282-7017

Important Notice
To All Church Members

Dear Member:

We are providing information about a program of total Medicare Supplement protection.

A most significant feature is that it **pays 100% of the difference** between what a doctor charges and what Medicare pays. That is, payments are not limited to Medicare "approved" charges. This program simply pays the difference . . . **all of it!** Of course, it also pays the deductibles under Part A Medicare.

The purpose of our inquiry is to verify interest in a truly complete package of Medicare Supplement coverage at an exceptionally favorable cost.

To this end, we would appreciate your cooperation in filling out the questionnaire on the reverse side. A postage paid envelope is enclosed. Thank you for your attention.

Bob Rogers

Bob Rogers
Christian Brotherhood

Form S100

Christian Brotherhood is not affiliated with any church or denomination

1. In terms of hospital and medical coverage, how would you describe your present policy?
   - ☐ Very Adequate
   - ☐ Moderate
   - ☐ Poor

2. Are you concerned about rising costs of hospital and doctor's services?
   - ☐ Yes
   - ☐ No

3. Will your present policy pay 100% of the actual difference between the amount paid by Medicare and the physicians' and surgeons' charges?
   - ☐ Yes
   - ☐ No

4. Assuming the costs were reasonable, would you be interested in seeing a plan such as described here made available to church members?
   - ☐ Yes
   - ☐ No

Thank You For Your Help

Please return the questionnaire in the enclosed postage paid envelope.

Name ______________________________ Age____________
Address ____________________________ Phone____________
City ________________ State________ Zip____________
County________ Church________________________

MATURE CITIZENS ASSOCIATION®

MATURE 65® — MEDICAL CARE PROTECTION®

5720 LBJ Freeway, Suite 200
Dallas, Texas 75240-6334

Dear Medicare Member.

Well it's happened again this year! Once again there has been an **increase** in the portion of your medicare bills and deductibles which you are required to pay!

As you know, Medicare was not designed to pay all of your health care expenses. Since Medicare began, the share you pay has **increased** over 1200%.

The Federal Medicare System **pays only about 40%** of your medical expenses. As a result you are being forced to pay more and more medical bills yourself.

Many senior citizens have turned to private insurance coverage to try to fill the gap, however many private insurance plans do not provide this medical protection.

With your help, however, there may be a solution to this problem.

Provided the cost is reasonable, would you be interested in seeing a Medicare Supplement Policy designed to help fill the gaps of Medicare? **PLUS: The Policy Pays On EYEGLASSES PRESCRIPTIONS, CHIROPRACTOR, DENTAL SERVICE AND PRIVATE NURSE BENEFITS.**

IF SO, WE WOULD LIKE TO HEAR FROM YOU — JUST FILL OUT AND MAIL THE POSTAGE FREE CARD. We will have a policy presented and explained to you for your review and examination.

The Association's underwriting company is Bankers Commercial Life Ins. Co., an Old Line Legal Reserve Stock Company with 32 years of continuous service. — The Association and the underwriting company are under the same management.

FILL OUT AND MAIL THE ATTACHED POSTAGE FREE CARD TODAY

— YOU ARE UNDER NO OBLIGATION WHATSOEVER —

Sincerely,

MATURE CITIZENS ASSOCIATION®

Form M.P.A.B.D. (8-86)
4 AG Adv. (1-87)

VERY IMPORTANT FEATURES:

- ★ **There Is NO Lifetime Aggregate Maximum Amount Of Benefits Payable Under This Policy NOR Is There Any Lifetime Aggregate Maximum Amount Payable On Any Benefit Outlined In This Policy Regardless Of The Amount Of Benefits The Company Pays To Any Insured Member Or Has To Pay In Future Years.**
- ★ **There Is NO LIMIT As To Number Of Benefit Periods Payable To Any Insured Member.**
- ★ **This Policy Is Designed To Help Fill The Gaps Of Medicare On The Expenses Authorized By Medicare Including 100% Of The Part A Deductibles. It Also Will Help Fill The Gaps Of Your Medical And Surgical Expenses That You Are Responsible For Paying Under Medicare's Part B. You Will NEVER Have To Update Your Policy Again As The Benefits Of This Policy Automatically Increase As You Become Responsible For Paying More. ALSO Benefits This Policy Pays On That Medicare Does NOT, SUCH AS: EYEGLASSES PRESCRIPTIONS, DENTAL, PRIVATE NURSE BENEFITS AND CHIROPRACTOR TREATMENTS.**

YOU ARE UNDER NO OBLIGATION WHATSOEVER

ADDITIONAL IMPORTANT FACTS

PAYS FULL POLICY BENEFITS WHETHER YOU ARE COVERED UNDER WORKMEN'S COMPENSATION OR NOT OR WHETHER YOU ARE COVERED UNDER ANY SIMILAR LAW OR NOT.

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STATEMENT HON. FRANK HORTON, A U.S. REPRESENTATIVE IN CONGRESS

MR. CHAIRMAN,

I APPRECIATE THE OPPORTUNITY TO SUBMIT THIS TESTIMONY TO THE SENATE FINANCE COMMITTEE AS IT REVIEWS THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988 AND I COMMEND THE CHAIRMAN ON HIS DECISION TO HOLD HEARINGS ON THIS ISSUE.

AS YOU ARE AWARE, I AM CURRENTLY A COSPONSOR OF H.R. 169. THIS LEGISLATION SEEKS TO REPEAL THE CATASTROPHIC CARE BILL AND CREATE A COMMISSION TO STUDY ALTERNATIVES FOR MEETING THE CATASTROPHIC HEALTH CARE NEEDS OF OUR NATIONS ELDERLY AND DISABLED. I ALSO SERVE ON THE HOUSE REPUBLICAN RESEARCH COMMITTEE'S TASK FORCE ON THE CATASTROPHIC LAW ALONG WITH ALMOST ONE-THIRD OF THE REPUBLICAN MEMBERS OF THE HOUSE OF REPRESENTATIVES.

I WOULD LIKE TO POINT OUT THAT IT IS NOT ONLY REPUBLICANS IN THE HOUSE WHO BELIEVE THAT WE MUST ACT TO CHANGE THIS LEGISLATION. OVER 175 OF MY COLLEAGUES IN THE HOUSE - REPUBLICANS AND DEMOCRATS - ARE COSPONSORS OF LEGISLATION TO SCALE BACK, DELAY, OR REPEAL THE CATASTROPHIC CARE BILL.

I RECENTLY RETURNED FROM MY ANNUAL OFFICE HOURS TOUR OF THE TWENTY-NINTH CONGRESSIONAL DISTRICT. I WAS VISITED BY THOUSANDS OF CONSTITUENTS AS I TRAVELLED TO SMALL TOWNS IN MY DISTRICT.
BY FAR AND AWAY, THE GREATEST CONCERN OF THESE CITIZENS WAS THE "SUPPLEMENTAL PREMIUM" RESULTING FROM THE CATASTROPHIC LAW.

MR. CHAIRMAN, THIS SO-CALLED "SUPPLEMENTAL PREMIUM" IS NOTHING MORE THAN AN INCOME TAX INCREASE. THIS UNFAIR TAX REPRESENTS A TREMENDOUS FINANCIAL BURDEN TO OUR CONSTITUENTS LIVING ON FIXED INCOMES. OF ONE THING I AM SURE, THE OUTCRY THAT WE HAVE HEARD IN CONGRESS THUSFAR IS NOTHING COMPARED TO WHAT WE WILL EXPERIENCE WHEN AMERICA'S SENIOR CITIZENS FILE THEIR TAX RETURNS NEXT APRIL.

DURING MY 27 YEARS IN CONGRESS, I HAVE CHAMPIONED EFFORTS TO PROTECT INDIVIDUALS FROM THE DEVASTATION OF CATASTROPHIC AND LONG-TERM ILLNESSES. I FIRMLY BELIEVE THAT THIS GOAL CAN BE ACHIEVED AND INTEND TO CONTINUE WORKING TOWARDS THIS END. THE PUBLIC OUTCRY OVER THE MEDICARE CATASTROPHIC COVERGE ACT OF 1988 HAS SHOWN THAT THIS IS NOT THE BEST WAY OF PROTECTING AMERICAN CITIZENS.

I URGE THE COMMITTEE TO HEED THE OPPOSITION TO THIS LAW EXPRESSED BY HUNDREDS OF THOUSANDS OF CONSTITUENTS. BY CREATING A COMMISSION OF EXPERTS, WE CAN BEGIN TO CRAFT LEGISLATION TO PROTECT MEDICARE RECIPIENTS FROM CATASTROPHIC AND LONG-TERM ILLNESS WHILE RESOLVING PROBLEMS WITH THE CURRENT FINANCING MECHANISM. LET'S REPEAL THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988 AND WORK TOGETHER TO CREATE A MORE FAIR, EQUITABLE LAW!

PREPARED STATEMENT OF THOMAS J. KILCLINE

Dear Mr. Chairman: I am Vice Admiral Thomas J. Kilcline, United states Navy, Retired, President of The Retired officers Association (TRCA) which has its national head quarters at 201 North Washington Street, Alexandria, Virginia. Our association has a membership of 308,000 retired, regular, reserve, and active duty officers of the seven Uniformed Services. In addition, our membership includes 54,000 auxiliary members who are survivors of members.

I genuinely appreciate this opportunity to address the Committee about the Medicare Catastrophic Protection Act of 1988, which in the interest of brevity I'll refer to throughout my statement as CATCAP. When CATCAP was passed there was an immediate response of satisfaction. But, you will recall, those who- had the time to study the law expressed concerns early in the legislative process about the flaw in the law's financing mechanism.

In the ten months since CATCAP was enacted, I have traveled around the country extensively. While visiting our own TRW chapters and councils, making presentations to civic groups and participating in meetings with other leaders interested in the impact of this law on the elderly, I noted an obvious and rapidly growing discontent with the law. Such dissatisfaction continues to increase as senior taxpayers learn more about the law. Their discontent seems to be centering on the unfairness of the law and relatively heavy financial burden they must shoulder for a program many don't need nor want.

Today, I will focus on the most penetrating issues raised by our members.

SHARED RESPONSIBILITY: Feelings of unfairness are mounting as elderly Americans realize that about 40 percent of those 65 and older who pay income taxes will foot the lion's share of the cost of Medicare catastrophic protection, not just for themselves but for the 18 million Medicare eligibles who will not pay Federal income taxes!

Forcing senior Americans to shoulder the entire burden of CATCAP is inconsistent with the social security principles upon which Medicare is based. Add-on taxes in one's senior years places a stressful burden on Americans who have planned futures based on the expectation that their medical needs would be met by Medicare and Medigap policies.

Americans are accustomed to sharing the cost burden of our national programs. The user fee principle inherent in CATCAP, however, can not withstand the tests of equity and fairness Americans have come to expect in national programs. Placing a health care user fee on elderly Americans is viewed as flagrant age discrimination which is now generating the staggering level of national repugnance that such a scheme warrants. Mr. Chairman, I don't believe the American people will accept this. opposition will not evaporate.

The elderly also express disbelief at being bridled with a significant part of the cost of providing CATCAP protection to the 3 million disabled Medicare beneficiaries under 65. While it's true that those disabled under 65 who pay Federal income tax will also be subject to the CATCAP surtax, data from the General Accounting Office show that 10 percent of Medicare beneficiaries are disabled, but will receive approximately 21 percent of the CATCAP benefits. In an independent assessment, David A. Sclar, Professor of Pharmacy at the University of Southern California, indicated that about 40 percent of the new CATCAP drug benefit will go to people under 65.

We agree that the government has an obligation to provide care to the indigent and disabled or those who contract debilitating illnesses. Where we disagree is on who should be responsible for paying the bill. We believe the burden should rest squarely on the shoulders of all taxpayers not just the 40-45 percent of Americans 65 or older who will pay the surtax.

OPEN-ENDED The surtax grows from 15 percent of Federal income tax in 1989 to 28 percent by 1993. Each year thereafter the law contemplates that the surtax will increase an additional I percent. In addition, the maximum liability per beneficiary is being adjusted upward each year to cover 63-percent of the costs. This surtax formula will generate geometric tax increases for senior American taxpayers.

There's another aspect that needs clarification. The surtax is not a tax on the wealthy. It's a tax on middle class senior citizens with modest incomes. For example, based on income tax calculations prepared by the accounting firm of Ernst and Whinney, a couple with a taxable income of $52,465 will pay the maxim surtax of $1,600 in 1989. In 1990, because the surtax rate increases 67 percent (i.e., to 25 percent) the taxable income threshold for a couple to be bridled with the maximum $1,700 surtax drops to $39,000. Hardly what one might categorize as wealthy. In fact, Mr. Chairman, the surtax is regressive and has little impact on the wealthy.

The table here illustrates the surtax as a percent of 1989 adjusted income tax liability for taxable incomes up to $1,000,000 (married filing jointly). As indicated, the surtax for the truly wealthy is less than .6 percent.

Taxable Income	Federal Income Tax	Surtax	Percent Surtax
$20,000	$3,000	$450	15.00
35,000	5,776	866	15.00
52,465	10,816	1,600	15.00
100,000	25,234	1,600	6.34
300,000	85,120	1,600	1.88
500,000	141,120	1,600	1.13
1,000,000	281,120	1,600	.57

DUPLICATION OF BENEFITS: Another very significant observation is that CATCAP law has essentially negated competitive market forces which already have accommodated the needs of the vast majority of Americans who are now being taxed to pay for a benefit that they never neither need nor want. When I say the Government has usurped market forces, I mean that beneficiaries have no choice in this CATCAP matter. A significant number of the people who will pay the freight for this law are very angry about being forced to enroll in a health care plan that provides less protection at higher cost.

Even though the large majority of those who will pay the surtax already have Medicare supplemental insurance, which covers- everything the CATCAP covers at a less cost, they are forced to participate in the CATCAP plan. For example, TROA's Medicare comprehensive supplemental policy (MEDIPLUS) includes a $1,000 catastrophic cap. Once a beneficiary has incurred $1,000 in medical expenses, TROA's supplemental pays the full cost of Medicare approved procedures even if the billed charges exceed Medicare allowable charges—a feature not incorporated in CATCAP. The TROA supplemental includes 100 percent coverage for hospitalization for as long as care is needed. Finally, once a member's $75 deductible is met, TROA's supplement pays the individual's cost-share amounts, something LAB will not pay until $1,370 in outpatient costs are incurred.

The cost of this coverage is only $321 per year for members and $356 per year for spouses. The additional $35 premium charged the spouse is used to defray the costs of providing surviving spouses *seven years* of MEDIPLUS coverage *at no cost* if the member predeceases the spouse.

CRUEL DECEPTION: For many senior citizens, the cruelest deception of all is that the CATCAP law does not address the financially debilitating costs associated with long-term nursing home care or long-term home care. In retrospect, it's no wonder that senior citizens gave their elected officials the impression they favored CATCAP. They were led to believe that the law provided catastrophic coverage and, because of confusion over the skilled nursing facility coverage and spousal impoverishment provision, thought the catastrophic protection included long-term nursing home care. The latter is the real financial catastrophe confronting the more than 1.5 million Americans who, each year, must pay costs of $25,000 or more.

Now that they realize that the "catastrophic protection" is limited to long term hospitalization, physician services and other duplicate coverage, they are disenchanted with the law and those who imposed it on them.

As the real impact of CATCAP becomes known and estimated surtax payments come due, a tidal wave of protest is building. From TROA's vantage point, never in the history of our organization have our members been so vocal or emotionally-charged over an issue. If real changes are not forthcoming, these protests will crest early in 1990 as the 12 million elderly dutifully pay the onerous surtax.

Seniors Say "NO" to Catastrophic Coverage Act: During the last ten months, stories, articles and editorials have covered this issue well. But there has been some doubt as to the attitudes of senior citizens toward the Act. In order to certify their attitudes, the Coalition for Affordable Health Care—39 organizations representing 18 million members-sponsored a survey by contracting with the Wirthlin Group, one of the most highly respected national survey and analysis organizations. The Wirthlin Group performed a telephone survey to determine the attitudes and opinions of senior citizens regarding the Act.

One thousand and eight interviews were conducted between 9 and 11 May using 20 questions which were meticulously designed to remove as much bias, doubt and confusion as possible. I would like to briefly share with the Committee the results of that survey.

The first major finding is that the senior citizens do not consider the Act worth the cost to them. (Chart #1)

But, let me give you some specific data to show how we arrived at this statement. The stage for this survey was set, *not* by announcing the subject of the survey, but by asking those interviewed to identify the number one problem facing senior citizens (Chart #2). 45 percent cited health care issues and that number included the 29 percent worried about health care costs.

Not only have our senior citizens recognized this as a real problem but they have done something about it (Chart #3). An astounding 84% have medical insurance in addition to Medicare.

These seniors, who have a concern and who have responded to it, are very representative of main stream America. As shown on Chart #4, 60% of those surveyed make less than $20,000 per year. Our senior citizens who are so concerned about health care are not wealthy, nor could this group be considered affluent.

Senior citizens have an awareness of the catastrophic legislation. 59% say they are familiar with the new law. (Chart #5). Those who know the law oppose it by a 53% to 31% margin. Significantly, 39% *strongly* oppose the legislation.

The survey shows an interesting attitude toward who should pay for health care costs (Chart #6). By a 52% to 35% margin, older Americans believe that "the elderly should share the responsibility with the federal government." As would be expected, income plays a major role in attitudes. Those with incomes below $10,000 and those with no additional health insurance favor the federal government assuming full responsibility for health care costs.

Six benefits of the Act were reviewed for relative importance (Chart #7). It should be noted that the catastrophic benefits already in effect and mammography screening are consistently rated higher by all demographic groups than prescription drug coverage or the $1,370 out of pocket limit.

If given a choice, seniors would choose private health care coverage to the catastrophic coverage provided under the law by a margin of 42% to 33% (Chart #8). This 9% margin is consistent throughout all the groups tested.

Given these data, it is not at all surprising that senior citizens do not feel the benefits of the coverage are worth the cost (Chart #9). While 55% share this view, the importance of the answer is that 44% feel strongly about it. The sentiment cuts across all of the 29 demographic and geographic groups tested, regardless of politics, age, income or even support for the Act.

A great disappointment in the Act has been that it does not cover long-term care (Chart #10). This is reflected in a significant 65% to 19% margin in favor of a new long term care program. Even those who are aware of and favor the current legislation believe it should be replaced by 61% to 31%.

Our senior citizens face a great challenge in providing for their health care as they face the increased probability of illness as they age. The leaders of our government recognize the challenge and in their efforts to address the problem of catastrophic expenses, they passed an Act that missed the mark. The data you have been shown demonstrate that the discontent of the senior citizens is widespread. Those complaining are not the well-too looking for a free ride. They are mainstream Americans, willing to pay their share. (A copy of the survey questionnaire and the results is enclosed for further reference).

MILITARY UNIQUE INEQUITIES: The law does not recognize that the majority of veterans with service connected disabilities will use VA facilities almost exclusively. As a result they are not a burden on the Medicare program and should not be subject to the surtax. The valid question they ask is why they should be forced to pay a surtax for care they've earned, while the major beneficiaries of the catastrophic law-those who do not have Medigap policies-will not pay the surtax.

A related disparity involves military retirees who have lifetime eligibility for space available care in military medical treatment facilities. The majority of these military retirees have access to prescription drugs at no cost in military pharmacies. Federal civilians receive adjustments in their Federal Employees Health Benefit Plan premiums for supplies and services obviated by CATCAP. However, military retirees do not receive similar adjustments for military health care they receive. I'm sure you can appreciate that military retirees are asking why a similar accommodation was not also made for them through a surtax reduction.

Finally, because of a technical mixup, the Governmental retiree exclusion does not apply to military retirees. The law grants a surtax exclusion to government retirees who receive annuities under *Section 72 of the Internal Revenue Code of 1986*. This exclusion applies to government retirees who have earned little or no social security benefits, and as such were disadvantaged for surtax purposes when compared to senior citizens who receive non-taxable social security wages. The maximum social security income to qualify for the governmental retiree exclusion is $6,000 for a single taxpayer, $9,000 for a joint return and $4,500 for a married taxpayer filing separately. These ceilings will be adjusted by future social security COLAs. In 1989, the maximum surtax reduction is $135 for a single taxpayer and $202.50 for a couple filing a joint return.

When language to incorporate this exclusion in the CATCAP law was being prepared, we were assured by its architects that it would apply to military retirees as well as civilian governmental retirees. However, because the IRS considers military retired pay to be compensation under *Section 61* of the Code, military retirees have been denied the exclusion. There are approximately 44,000 military retirees who retired prior to 1957 who are potentially eligible for the exclusion. The exact numbers will depend on whether they engaged in social security covered employment after retirement from the military. Regardless of the numbers, simple equity demands that military retirees be afforded the same surtax exclusion that is available to civilian governmental retirees.

I trust that these types of technical and administrative changes to CATCAP will be corrected by the Committee this year.

Summary: It is not TROA's intent to dismantle the Medicare catastrophic Coverage Act. Our interest is for Congress to revisit CATCAP to determine if the real needs of senior citizens are being met and to urge the committee to develop a fairer funding mechanism. There's a lot of confusion about whether the program is overfunded or underfunded. There are people out there who have good ideas about fairer funding alternatives. We think the Congress should hear those alternative ideas about how to accomplish the desired policy objectives.

The data I have shared with you indicates widespread discontent by seniors with CATCAP. Those who are discontented are not the well-too looking for a free ride. They are mainstream Americans willing to pay their share.

S. 335 provides the blueprint we believe is essential to addressing the growing concerns of senior citizens. Consistent with our survey, it preserves the Part A benefits already in effect and spousal impoverishment provisions while delaying the surtax and other benefits for one year. This delay will afford Congress the opportunity to reevaluate and identify the real health care needs of senior citizens. We strongly endorse its enactment.

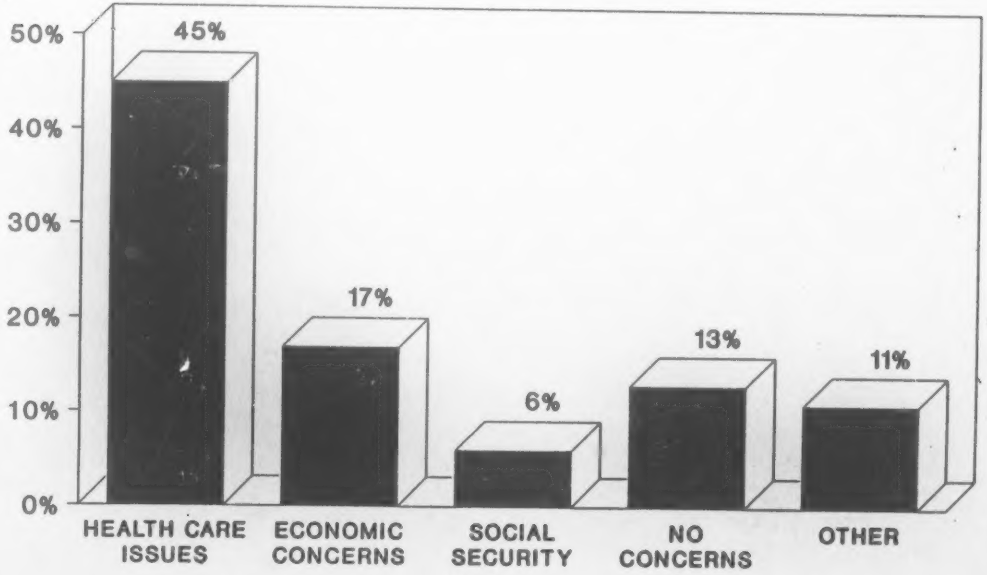
The following associations align themselves with the foregoing remarks: Fleet Reserve Association; Non-Commissioned Officers Association; Association of the U.S. Army; Reserve Officers Association; National Association for the Uniformed Services; Air Force Sergeants Association; and Air Force Association.

SUMMARY OF FINDINGS

The Act is not worth the cost.

Chart 1

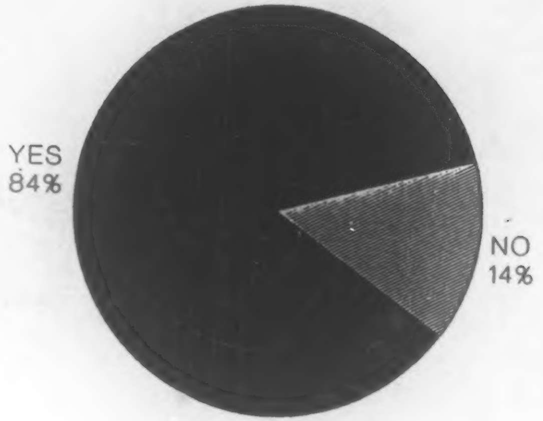
MOST IMPORTANT PROBLEM AMONG OLDER AMERCANS: NET RESPONSES



WIRTHLIN GROUP SURVEY: May 9-11, 1989

Chart 2

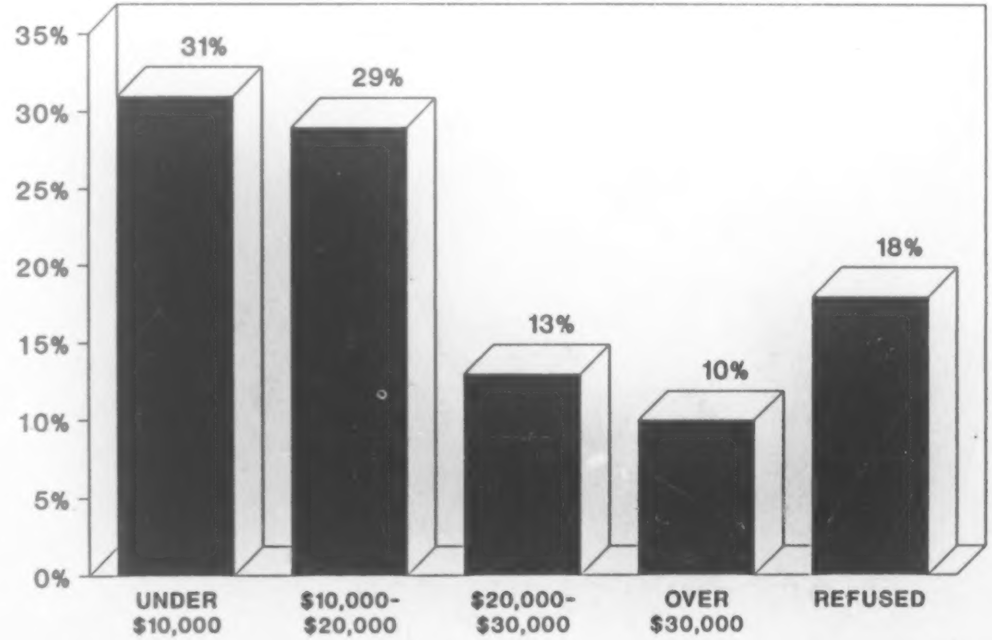
Do you have any medical insurance in addition to Medicare?



WIRTHLIN GROUP SURVEY: May 9-11, 1989

Chart 3

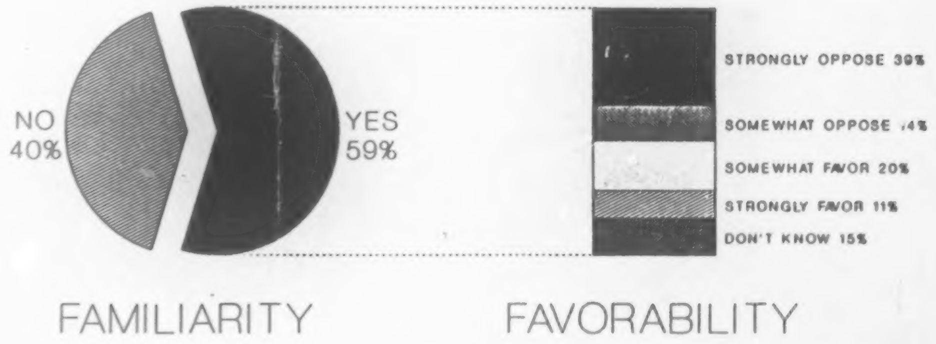
INCOME DISTRIBUTION



WIRTHLIN GROUP SURVEY: May 9-11, 1989

Chart 4

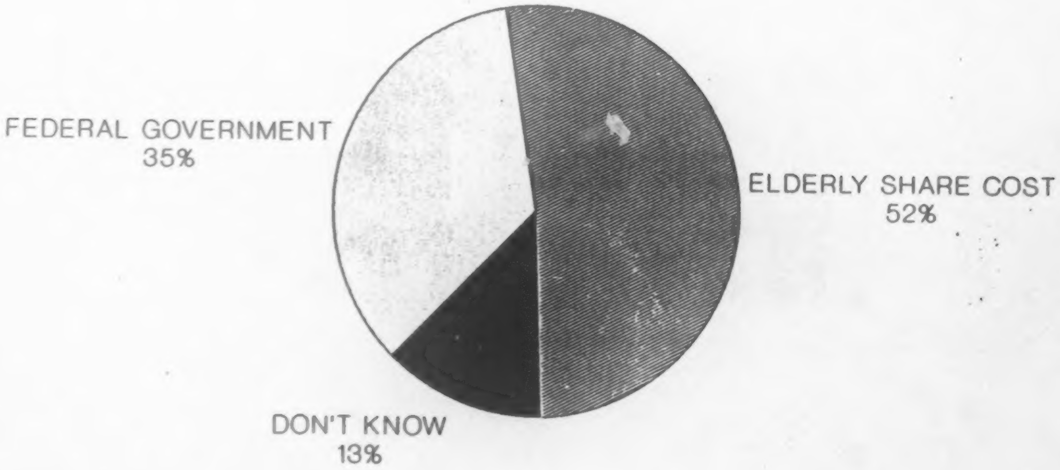
FAMILIARITY & FAVORABILITY
MEDICARE CATASTROPHIC COVERAGE ACT



WIRTHLIN GROUP SURVEY: May 9-11, 1989

Chart 5

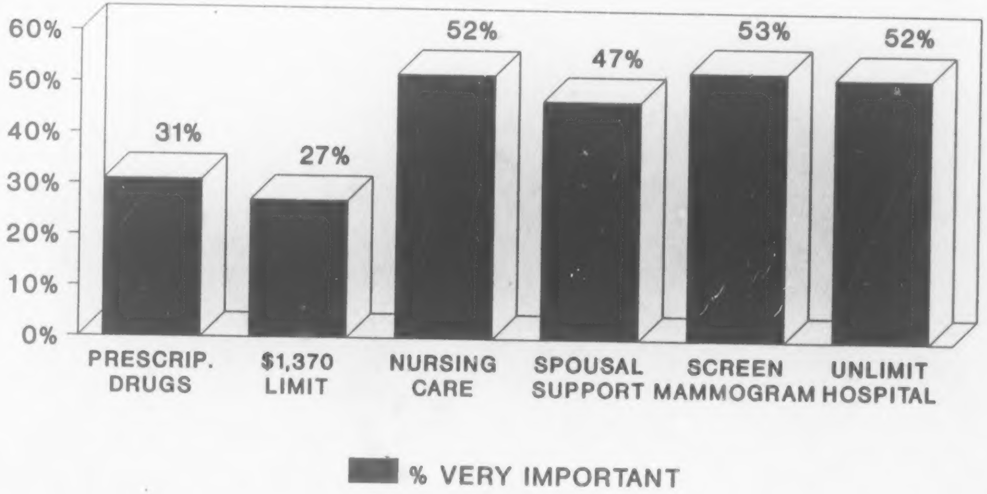
Who should have the responsibility of paying for health care costs?



WIRTHLIN GROUP SURVEY: May 9-11, 1989

Chart 6

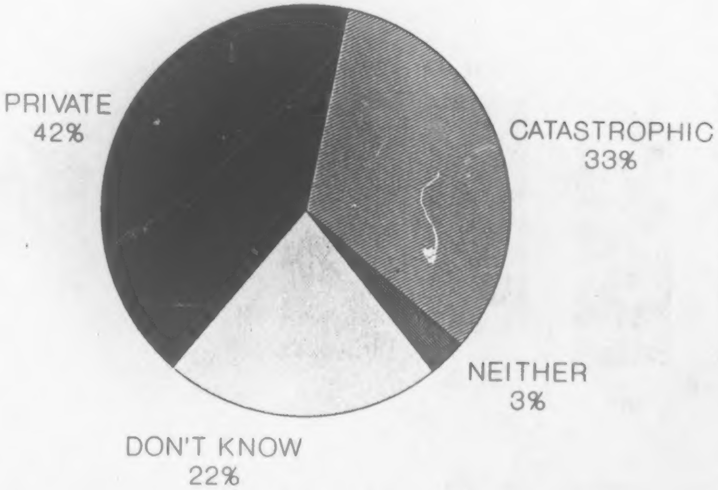
CATASTROPHIC COVERAGE ACT BENEFIT RATINGS (ON A 1 TO 10 SCALE)



VERY IMPORTANT = RESPONDING 8, 9, or 10
10 = "EXTREMELY IMPORTANT"
WIRTHLIN GROUP SURVEY: May 9-11, 1989

Chart 7

if given a choice, would you prefer the catastrophic coverage or would you prefer private coverage?

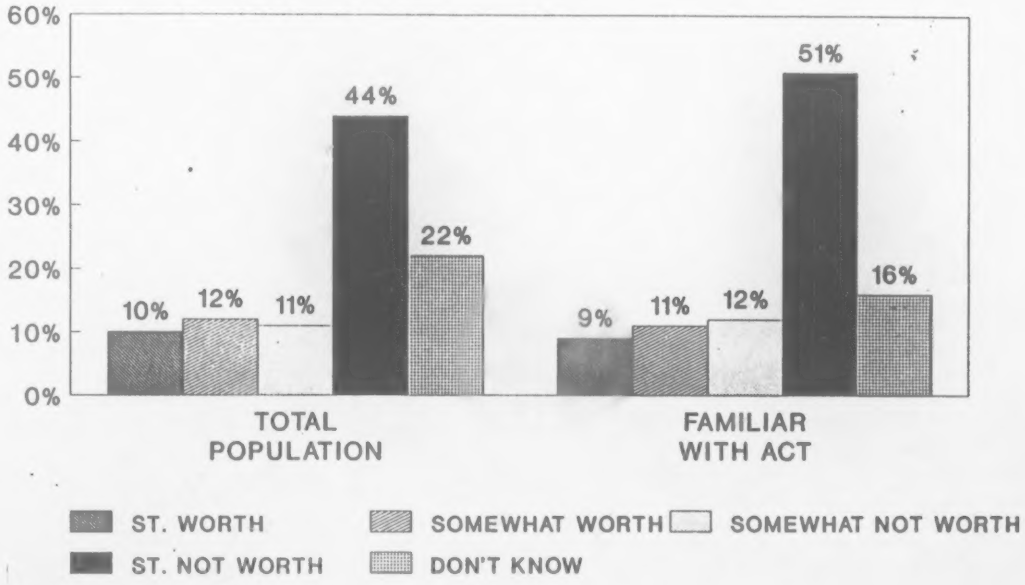


WIRTHLIN GROUP SURVEY: May 9-11, 1989

Chart 8

9

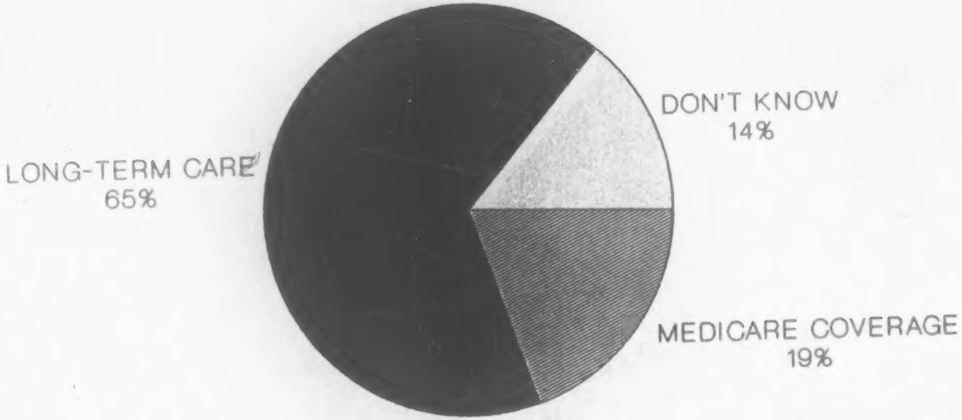
Do you feel the benefits of the coverage are worth the cost?



WIRTHLIN GROUP SURVEY: May 9-11, 1989

Chart 9

Do you prefer Medicare Catastrophic Coverage or a new long-term care program?



WIRTHLIN GROUP SURVEY: May 9-11, 1989

Chart 10

The Wirthlin Group

MEMORANDUM

TO: ADMIRAL T.J. KILCLINE

FROM: NEIL NEWHOUSE -- THE WIRTHLIN GROUP

SUBJECT: MEDICARE CATASTROPHIC COVERAGE ACT SURVEY

DATE: MAY 15, 1989

As you know, we recently completed a national survey for the coalition probing the attitudes and opinions of senior citizens regarding the Medicare Catastrophic Coverage Act.

One thousand and eight telephone interviews were completed with senior citizens across the country on May 9-11, 1989. Although the methodology for the survey is more fully explained in the summary of findings, the margin of error for this sample is ± 3.1%.

The key findings of the survey are as follows:

- o Senior citizens believe that health care is the most important problem facing the elderly. Almost half of all seniors interviewed (45%) cite health care or health care costs as most important.
- o Those seniors who are aware of the new Medicare Catastrophic Coverage Act (59%) oppose it by a 53%-31% margin, with 39% saying they strongly oppose the legislation.
- o After having reviewed six key benefits included in the new Medicare Catastrophic Coverage Act, more than half of the seniors interviewed (55%) believe that the benefits are not worth the cost of the Act. This belief is held by all age, income, and partisan groups.
- o Even those seniors who are aware of the legislation, and favor it, believe that the benefits aren't worth the cost of the program (42%-38%).
- o A new long-term program is preferred to the current legislation by a 65%-19% margin.

These results are all the more interesting considering the fact that 85% of those seniors surveyed say they have medical insurance in addition to Medicare, and 60% of those interviewed have less than $20,000.

It is clear from this survey that senior citizens are very concerned about the catastrophic legislation. It is important to note that throughout the survey, those who feel strongest about the legislation are invariably opposed to it. The concern about the legislation and its worth repeatedly cuts across all age, income, and partisan lines.

In summary, the more that seniors learn about this legislation, the more likely they are to oppose it.

The Wirthlin Group

MEDICARE CATASTROPHIC COVERAGE ACT SURVEY KEY POINTS

METHODOLOGY

One thousand and eight Americans at least sixty-five years of age were interviewed by telephone by The Wirthlin Group on May 9-11 for this project. The respondents represent a random selection of older Americans from all parts of the country and all income levels.

The margin of error for this survey is ± 3.1%, meaning that should this survey be repeated, 95 times out of 100, the results for each question would be within three percentage points of our findings.

The questionnaire was twenty questions long, and the interviews averaged about thirteen minutes in length.

Demographically, the sample of 1,008 senior citizens included 59% women, 41% men, and had the following characteristics:

AGE	
65-69	32%
70-74	27%
75-79	21%
80+	19%

INCOME	
Under $5,000	12%
$5,000, but less than $10,000	19%
$10,000, but less than $15,000	17%
$15,000, but less than $20,000	12%
$20,000, but less than $25,000	9%
$25,000, but less than $30,000	4%
Over $30,000	10%
Refused	18%

REGION OF COUNTRY	
Northeast	26%
South	31%
Midwest	23%
West	20%

PARTISAN AFFILIATION	
Republican	31%
Independent	28%
Democratic	40%

MOST IMPORTANT PROBLEM FACING SENIOR CITIZENS

Forty-five percent of older Americans believe that health care issues are the most important problem facing seniors, with the leading single problem being health care costs (29%).

The concern over health care cuts across every demographic group tested on this survey -- of the 29 demographic and geographic groups tested, all cite health care as their top issue.

General economic concerns (totalling 17%), such as inflation (14%) and taxes (2%) were the next most often mentioned problems, followed by social security/medicare (11%). Thirteen percent of older Americans commented that they had no major concerns or problems.

Lower income seniors stand out on this question as rating economic concerns (especially inflation - 20%) especially high.

ATTITUDES TOWARD RESPONSIBILITY FOR PAYMENT OF HEALTH CARE COSTS

By a 52%-35% margin, older Americans believe that "the elderly should share the responsibility with the federal government for paying health care costs," rather than the federal government assuming "the complete responsibility for the payment of health care costs for the elderly." Thirteen percent of seniors were undecided on this issue.

Income plays a major role in seniors' attitudes on this question. The lower the income level (especially those with income levels of less than $10,000 per year), the more divided they are on this question, with a plurality (48%-41%) believing that the federal government should assume the complete responsibility for the payment of health care costs.

On the other hand, sixty percent of seniors with household incomes of at least $10,000 believe that the elderly should share the costs.

Other key points on this question include:

- o A majority of both Republicans (59%) and Independents (52%), and a plurality of Democrats (47%) believe that the elderly should share the responsibility with the federal government.
- o Those seniors who are not covered under any additional insurance program like Blue Cross/Blue Shield (14% of entire sample) favor the federal government assuming the complete responsibility for the health care costs (46%-39%).

AWARENESS AND SUPPORT FOR MEDICARE CATASTROPHIC COVERAGE ACT

Fifty-nine percent of seniors interviewed said that they are aware of the Medicare Catastrophic Coverage Act.

Those most likely to say they are aware of the Act include men (64%) higher income seniors (82%), and those seniors under the age of 80 (61%). Those seniors without additional insurance coverage were least likely to have heard of the new law, with just 34% saying they were aware of it.

When those who were aware of the new law were asked whether they favored or opposed the legislation, 51% were in opposition to it, 31% in support of it, and 15% undecided.

Interestingly, 39% of this group said that they were strongly opposed to the new law -- indicating a strongly felt opposition to the law.

Of the 29 demographic and geographic groups tested, every one opposed the new law, including Republicans (59%-27%) and Democrats (49%-33%), lower income seniors (41%-35%), and those without additional insurance (48%-31%).

IMPORTANCE OF BENEFITS OF THE MEDICARE CATASTROPHIC COVERAGE ACT

Seniors were asked to rate the importance to them of a number of benefits provided by the Act on a scale from 1-10, with 1 being "not at all important," and 10 being "extremely important."

As you can see below, coverage for mammography screening, unlimited hospitalization, and skilled nursing care topped the list of benefits rated by seniors, with 52%-53% of respondents rating them as highly important (rating "8," "9," or "10").

- Coverage for women undergoing mammography screening.
  (53% rating as highly important)
- Unlimited hospitalization coverage after you pay an annual $560 deductible.
  (52% rating as highly important)
- 150 days of skilled-nursing care for a year, after the individual pays the first $170.
  (52% rating as highly important)
- A benefit that increases the amount of income and property a spouse may retain when their husband or wife goes to a nursing home at Medicaid expense.
  (47% rating as highly important)
- 50% coverage for prescription drugs after the individual pays the first $600 per year in 1991.
  (31% rating as highly important)
- $1,370 annual out of pocket limit on how much Medicare recipients will have to pay for "reasonable and proper" Medicare-approved physician and other outpatient service in 1990.
  (27% rating as highly important)

Although there isn't a great deal of difference between how men and women rank the importance of these benefits (men do rate mammography screening highly), there is some difference by income level. The findings show that both skilled nursing care and mammography screening are rated higher by lower income seniors than they are by those with higher incomes.

Furthermore, it should be noted that the catastrophic benefits already in effect and mammography screening are consistently rated higher by all demographic groups than prescription drug coverage or the $1,370 out of pocket limit.

CHOICE BETWEEN CATASTROPHIC COVERAGE OR PRIVATE COVERAGE

After having reviewed the key benefits of the catastrophic coverage, seniors were asked the following question:

> The Catastrophic Coverage Act applies to all Medicare enrolles whether or not they choose to participate in the plan. In some cases, this includes duplication in existing coverages. If given a choice, would you prefer the catastrophic coverage or would you prefer private coverage?

Seniors opt for private coverage by a 42%-33% margin, with 22% being undecided, and another 3% respond "neither."

The crosstabs indicate that while the overall margin is just nine points, the sentiment in favor of private coverage is widespread -- only two of the groups tested favor catastrophic coverage rather than private coverage (those with incomes under $10,000, and women with incomes under $20,000).

Other key findings on this question include:

- Republicans (49%-30%), Democrats (39%-35%), and Independents (37%-33%) all favor private coverage.
- Those seniors who do not have additional insurance coverage are divided on the question (36%-36%).
- Respondents who earlier said that the federal government should assume the complete responsibility for the payment of health care services to the elderly favor private coverage by a narrow 38%-37% margin.

LONG-TERM CARE

When seniors are informed that the 1988 Medicare Catastrophic Coverage Law and its previously mentioned benefits does not cover long-term care, and subsequently asked whether they would prefer the current law or a new long-term care program, they choose the new program by a wide 65%-19% margin.

The sentiment in favor of a new program cuts across every group tested, with at least 58% of all groups opting for a new long-term care program. Even those seniors who are aware of and favor the current legislation believe it should be replaced by a new long-term care program (61%-31%).

MEDICARE CATASTROPHIC COVERAGE ACT BENEFITS WORTH THE COST?

When seniors are informed that in order to fund this new program, they will be required to pay a surtax on their federal income tax payment of 15% for each $150 owed up to a maximum of $800 in 1989, they do not believe that the benefits of the coverage are worth the cost by a 55%-22% margin.

It is important on this question to also note that 44% of the seniors said that they feel very strongly that the benefits are not worth the cost of the program.

Again, this sentiment cuts across all groups, with the spread between the two sentiments never getting closer than 18 points.

Key findings on this question include:

- Even 45% of lower income seniors say that the benefits are not worth the costs involved.
- Republicans (55%), Democrats (56%), and Independents (56%) all agree that the benefits are not worth the costs of the program.
- Those seniors who were aware of the legislation and favored it previously now say it's not worth the cost (42%-38%).

INTERVIEW SCHEDULE

WIRTHLIN GROUP SURVEY
MEDICARE CATASTROPHIC CARE ACT
MAY 9-11, 1989
N = 1,008 AMERICANS, 65 AND OVER
MARGIN OF ERROR = ± 3.1%

1. First, what would you say is the number one problem facing senior citizens today, the one that you, yourself, are most concerned about?

INFLATION/HIGH PRICES	14%	TAXES	2%
HOUSING PRICES	1%	DEFICITS	*
HEALTH CARE COSTS	26%		
LACK/MEDICAL COVERAGE	4%	LONELINESS	3%
PROPER HEALTH CARE	8%	NO CONCERNS/PROBLEMS	13%
RAISE SOCIAL SECURITY	2%	OTHER	8%
LONG-TERM NURSING CARE	2%	NO OPINION	9%
		REFUSED	*
CUTTING SOCIAL SECURITY	1%		
SOCIAL SECURITY/MEDICARE RED TAPE	3%		
RISING MEDICARE COSTS	3%		
GENERAL MEDICARE	2%		

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2. Now, I'd like to read you two statements regarding the issue of health care for senior citizens, and I'd like you to tell me which one you agree with more.

The statements are ...

(ROTATE)

___ The federal government should assume the complete responsibility for the payment of health care services for the elderly.

... or ...

___ The elderly should share the responsibility with the federal government for paying health care costs.

FEDERAL GOVERNMENT	35%
ELDERLY SHARE COSTS	52%
DON'T KNOW (DO NOT READ)	13%
REFUSED (DO NOT READ)	*

As you may know, in 1988 Congress adopted legislation that expanded Medicare to provide catastrophic protection for disabled Americans and Americans age 65 or older. As a result, Medicare will cover the costs associated with extended hospitalization, doctor's service, and prescription drugs.
The program is funded by senior citizens who will pay a $4 monthly increase in Medicare premiums, plus a 15% surtax on each $150 owed in income tax in 1989.

3.	Are you familiar with the new law, which is called the Medicare Catastrophic Coverage Act?	YES (GO TO Q. 4)	59%
		NO (GO TO Q. 5)	40%
		DON'T KNOW (DO NOT READ)	2%
		REFUSED (DO NOT READ)	*

4.	Generally speaking, do you favor or oppose this legislation? (WAIT FOR RESPONSE, THEN ASK: Would you say that you strongly (favor/oppose) or just somewhat (favor/oppose) this legislation?	STRONGLY FAVOR	11%
		SOMEWHAT FAVOR	20%
		SOMEWHAT OPPOSE	14%
		STRONGLY OPPOSE	39%
		DON'T KNOW	15%
		REFUSED	1%

Now, I'd like to read you six benefits of the Medicare Catastrophic Coverage Act. After I read each one, I would like you to rate the importance to you personally of that benefit on a scale of 1 to 10, where 1 represents "Not at all important" and 10 represents "Extremely important." Of course, you may select any number between 1 and 10.

The first/next one is ...

5. 50% coverage for prescription drugs after the individual pays the first $600 per year in 1991.

ONE	21%
TWO	5%
THREE	4%
FOUR	3%
FIVE	12%
SIX	3%
SEVEN	4%
EIGHT	6%
NINE	3%
TEN	22%
DON'T KNOW (DO NOT READ)	12%
REFUSED (DO NOT READ)	3%

MEAN: 5.4

6. $1,370 annual out-of-pocket limit on how much Medicare recipients will have to pay for "reasonable and proper" Medicare-approved physician and other outpatient service in 1990.

ONE	15%
TWO	6%
THREE	4%
FOUR	3%
FIVE	13%
SIX	4%
SEVEN	4%
EIGHT	9%
NINE	3%
TEN	15%
DON'T KNOW (DO NOT READ)	19%
REFUSED (DO NOT READ)	4%

MEAN: 5.5

7. 150 days of skilled-nursing care a year, after the individual pays the first $170.

ONE	8%
TWO	2%
THREE	3%
FOUR	2%
FIVE	11%
SIX	3%
SEVEN	6%
EIGHT	14%
NINE	7%
TEN	31%
DON'T KNOW (DO NOT READ)	10%
REFUSED (DO NOT READ)	3%

MEAN: 7.2

8. A benefit that increases the amount of income and property a spouse may retain when their husband or wife goes to a nursing home at Medicaid expense.

ONE	9%
TWO	2%
THREE	2%
FOUR	1%
FIVE	10%
SIX	3%
SEVEN	4%
EIGHT	9%
NINE	4%
TEN	34%
DON'T KNOW (DO NOT READ)	17%
REFUSED (DO NOT READ)	4%

MEAN: 7.2

9. Unlimited hospitalization coverage after you pay an annual $560 deductible.

ONE	8%
TWO	4%
THREE	2%
FOUR	2%
FIVE	10%
SIX	3%
SEVEN	5%
EIGHT	10%
NINE	6%
TEN	36%
DON'T KNOW (DO NOT READ)	11%
REFUSED (DO NOT READ)	3%

MEAN: 7.3

10. Coverage for women undergoing mammography screening.

ONE	7%
TWO	4%
THREE	2%
FOUR	1%
FIVE	10%
SIX	4%
SEVEN	3%
EIGHT	8%
NINE	5%
TEN	40%
DON'T KNOW (DO NOT READ)	12%
REFUSED (DO NOT READ)	3%

MEAN: 7.4

11. The Catastrophic Coverage Act applies to all Medicare enrollees whether or not they choose to participate in the plan. In some cases, this includes duplication in existing coverages. If given a choice, would you prefer the catastrophic coverage or would you prefer private coverage?

CATASTROPHIC COVERAGE. . . .	33%
PRIVATE COVERAGE	42%
NEITHER (DO NOT READ) . . .	3%
DON'T KNOW (DO NOT READ) . .	22%
REFUSED (DO NOT READ). . . .	1%

Now, looking at another health care issue...

12. Long-term care refers to assistance provided to people who have a long-term disability, such as a stroke. Long-term care can be provided in a nursing home or at home by a professional caregiver. Long-term care is not provided by the 1988 Medicare Catastrophic Coverage Law. Given this information, which ONE of the following do you prefer ...

(ROTATE)

____ Medicare Catastrophic Coverage

... or ...

____ A new long-term care program

MEDICARE COVERAGE	19%
NEW LONG-TERM CARE PROGRAM .	65%
DON'T KNOW (DO NOT READ) . .	14%
REFUSED (DO NOT READ)	1%

13.	Now, knowing that in order to fund the Medicare Catastrophic Coverage Act, seniors will be required to pay a surtax on their federal income tax payment - 15% of each $150 owed in income tax up to a maximum of $800 in 1989. The surtax increases to 25% in 1990. Now, do you feel the benefits of the coverage are worth the cost? (WAIT FOR RESPONSE, THEN ASK: Do you feel very strongly or just somewhat strongly about your position?)	VERY STRONGLY WORTH	10%
		SOMEWHAT STRONGLY WORTH . .	12%
		SOMEWHAT STRONGLY NOT WORTH	11%
		VERY STRONGLY NOT WORTH . .	44%
		DON'T KNOW (DO NOT READ) .	22%
		REFUSED (DO NOT READ) . . .	1%

Finally, I would like to ask you some questions for statistical purposes ...

14.	What is your age please?	65 - 69	32%
		70 - 74	27%
		75 - 79	21%
		80 AND OVER	19%
		REFUSED (DO NOT READ) . . .	1%

15.	Which of the following categories contains your total family income? (READ CATEGORIES)	UNDER $5,000	12%
		$5,000 BUT LESS THAN $10,000	19%
		$10,000 BUT LESS THAN $15,000	17%
		$15,000 BUT LESS THAN $20,000	12%
		$20,000 BUT LESS THAN $25,000	9%
		$25,000 BUT LESS THAN $30,000	4%
		$30,000 OR MORE	10%
		REFUSED (DO NOT READ) . . .	18%

16.	Do you currently have any medical insurance in addition to Medicare, such as Blue Cross/Blue Shield?	YES	84%
		NO	14%
		REFUSED (DO NOT READ) . . .	1%

17. In politics today, do you generally think of yourself as:

(ROTATE)

___ a Republican

___ a Democrat

... or .. something else?

(FOR "REPUBLICAN/DEMOCRAT", ASK: Do you consider a strong (Republican/Democrat) or a not-so-strong (Republican/Democrat)?)

(FOR "SOMETHING ELSE," ASK:)

Do you consider yourself to be closer to the:

___ Republican Party

... or ...

___ Democratic Party

STRONG REPUBLICAN	14%
NOT-SO-STRONG REPUBLICAN .	17%
NOT-SO-STRONG DEMOCRAT . .	18%
STRONG DEMOCRAT	22%
LEAN REPUBLICAN	4%
HARD INDEPENDENT	19%
LEAN DEMOCRAT	5%
REFUSED (DO NOT READ) . . .	1%

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18. Sex (BY OBSERVATION)

MALE	41%
FEMALE	59%

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19. Geographic Region

NORTHEAST	26%
MIDWEST	23%
SOUTH	31%
WEST	20%

Prepared Statement of Senator Carl Levin

Mr. Chairman: It is now clear that many senior citizens view the new catastrophic health insurance law as imposing an unfair tax burden on them. I believe that the new benefits, such as 305 day-a-year hospital coverage and a limit on out-of-pocket expenses, provided under the new law are meaningful improvements over those previously available through Medicare. However, fairness cries out to change the current way in which those benefits are funded.

The supplemental premium surtax breaks new—and, I think, unwelcomed—ground in the principle of "ability to pay." I can think of no other instance in which we offer benefits to a group within society and require one portion of that group to subsidize another portion of that group based on the ability-to-pay. Do we require financially well-off veterans receiving service connected disability compensation—and no other taxpayers—to subsidize less well-off veterans compensation? No we don't, and we shouldn't. Why, as a matter of equity, then, should we require better off senior citizens—and no other taxpayers—to subsidize the benefits of other senior citizens of more modest means? Senior citizens are willing to share the burden, but they do not want to be singled out because of their age to shoulder the subsidy for other seniors who are involved in this program.

I have been told that this formula for funding the catastrophic health insurance program was the price that had to be paid for Reagan Administration support for the passage of this law. But I urge the Committee to recognize that it is a price which many of those outside of Washington who are on the receiving end of this legislation are unwilling to pay. I have met with many senior citizens on this issue. Let me tell you, sure, they don't like paying more in taxes. But what really eats at them is the felling that they have been singled out and asked to carry an extra burden to bring the costs of this program in line with the revenues. Let me tell you, they don't understand—and they shouldn't be asked to understand—why they are the only group in our society which is being asked to subsidize another part of their group. They know that this is the reason why the supplemental premiums are as large as they are under this new law.

They are pleased, Mr. Chairman, that you have indicated a willingness to reduce the size of the supplemental premium if it turns out that the premium is generating more revenue than was originally projected to be necessary to fund the program. They are amazed at the Administration's refusal to consider that possibility. They are deeply suspicious that the real reason for this reluctance to consider reducing the size of the premium is a desire by the Administration to use this "surplus revenue" to reduce the deficit without being accused of raising taxes.

The outrage among seniors over the current way in which the catastrophic health insurance program is funded is clear to see. What is not nearly as easy is to come up with a plan which retains the valuable services available under this program in a fiscally responsible manner and pays for them in a way that is fair. But it is possible.

I believe that the funding mechanism for the catastrophic health insurance program should be restructured so that it is consistent with the manner in which the pre-1988 Medicare law was funded. Therefore, the catastrophic health insurance program should be modified so that it is funded both out of an assessment on beneficiaries and out of general revenues.

This change would help to address the concern of many seniors that they are currently being singled out to pay for a program in a way that no other portion of society is being asked to pay. This change in financing would also recognize that in addition to there being a personal interest in health care for catastrophic illnesses, there is a broad societal interest in it. A decent society—and we are a decent society—cannot tolerate having its senior citizens make the choice between neglecting their own health or driving themselves and their families into poverty. The catastrophic health insurance program should be funded in a manner that recognizes this general societal interest.

The focus, then, must shift to the question of how to raise the general revenues necessary to supplement the basic premium in a way that ensures the financial solvency of the program. It would be possible to achieve this goal if we would amend the current law and keep the marginal income tax rate at 33% for families of four with taxable incomes over $208,510, or for singles with taxable incomes over $109,050 as Senator Harkin and I have proposed, instead of allowing the marginal rate to drop back to 28% as is provided under current law. This proposal would generate enough revenues in order to allow for the entire repeal of the supplemental premium and to be revenue neutral in the 1990–1994 period. Another advantage of the proposal, by the way, is that the maximum capital gains rate under this proposal would be reduced from 33% to 28%. This proposal would differ from the current supplemental premium because it would apply the "ability to pay" principle to the entire population and not just to seniors. In that context, applying the 33% marginal rate to families of four with taxable incomes above $208,510 and to singles with taxable incomes above $109,050 would only actually affect one percent of the taxpayers—the one million wealthiest among us who now pay a lower marginal tax rate than people earning less—and would give a tax cut to about 13 million senior citizens. Those 13 million arc the seniors who are now paying the tax surcharge. The 13 million include senior couples with incomes of $20,000 and up and single seniors with incomes of $15,000 and up.

I recognize that some people will immediately say that this proposal is not realistic because the American people view the 1986 Tax Reform rates as untouchable. I agree that most Americans do not want to see a general income tax increase affecting the average taxpayer. However, I believe that most Americans would support eliminating the existing anomaly in the tax code, which has people earning $80,000,000 paying a lower marginal tax rate than people earning $80,000 and I believe that most Americans would support applying the revenue generated from that change to achieve any number of purposes, including equity for seniors as the bill we announced yesterday would do.

I would urge the President and the members of Congress to hear the voices of our seniors on this point. The supplemental premium is unfair. That is why it is intensely unpopular. Applying the maximum 33% marginal rate to the highest income taxpayers married with a family of four with taxable incomes over $208,510 and singles with taxable incomes over $109,050—would be very popular.

Mr. Chairman, addressing the outcry against the supplemental premium is a challenge. But it is a challenge that can be met if we are willing look at the pieces of the puzzle before us and try to fit them together with the guidance of common fairness and common sense.

UNITED STATES SENATE

MEDICARE CATASTROPHIC COVERAGE SURTAX REPEAL ACT OF 1989

- Repeals entirely the Medicare catastrophic coverage supplemental premium surtax, effective 1989. Thirteen million senior citizens would receive a tax reduction.
- Retains all of the benefits provided under the Medicare Catastrophic Coverage Act of 1988.
- Leaves unchanged the current law affecting the basic monthly premiums that senior citizens pay under the Medicare Catastrophic Coverage Act of 1988.
- Extends the existing 33% marginal income tax rate which applies to some upper middle income and upper income taxpayers to the highest income taxpayers, effective 1990. *Under current law,* the 33% marginal rate will apply in 1990 to families of four with *taxable* incomes of between $78,350 and $208,510 (and for single individuals with taxable incomes between $47,000 and $109,050). *Under current law,* taxable incomes above those amounts are taxed at a 28% marginal tax rate. *Under the Medicare Catastrophic Coverage Surtax Repeal Act of 1989,* taxable incomes above those amounts would be taxed at the 33% marginal tax rate. Taxes would increase for 600,000 taxpayers, which is less than one percent of total taxpayers.
- Establishes a maximum capital gains rate of 28%, as compared with the current maximum capital gains rate of 33%.
- Revenue neutral over 5 years, 1990-1994.

PREPARED STATEMENT OF SENATOR JOHN MCCAIN

Mr. Chairman, I would like to commend you and the members of the Finance Committee for calling this hearing to revisit the "Medicare Catastrophic Coverage Act of 1988." As you know, there has been a firestorm among our nation's seniors over the adoption of the Act.

While I agree that the cost of the Act, and the way that it will be paid for, is of concern to seniors, seniors are saying to me that the mandatory nature of the Act and the benefit package it provides is of equal, if not greater, concern.

It is conversations with senior Arizonans, and the mail they send me, that has brought me to this belief—a belief which is only underscored by a national poll of seniors across the country conducted two weeks ago by the Wirthlin Group.

I would like to request that a copy of this poll be attached the end of my statement.[1]

In the eyes of the seniors, the Catastrophic Coverage Act is a good idea gone bad. From the onset of the debate over the original Reagan Administration proposal, it appeared that there was strong support among the seniors of this country for doing something in the area of catastrophic illness.

Originally the proposal was to provide seniors with the option of having coverage of long-term hospitalization expenses, for only a small increase in their Medicare premium. It also eliminated the coinsurance for hospital and skilled nursing facility services, and set a cap on what Medicare beneficiaries would have to pay out-of-pocket for medical expenses. But as the bill moved through Congress, it was amended and amended, and we finally ended up requiring seniors to purchase a package which duplicates many of the benefits already available in the private sector. Thus, not only did the cost increase, but the philosophy changed.

It seems the true issue in this controversy is not the Act's financing principle—that seniors should pay for catastrophic illness benefits provided under Medicare. In fact, Mr. Chairman, I think you stated during the introduction and debate over the Senate version that a consensus had developed in favor of the approach that any catastrophic benefits package ought to be paid for by those receiving the benefits. The real issue is that we are forcing the seniors of this country to buy a package of benefits that they do not feel are important enough to pay for.

I have heard from tens of thousands of seniors in my state regarding this subject. 30,000 senior Arizonans responded on a margin of 4-to-1 that they opposed the Senate version of the legislation. Over 20,000 Arizonans have contacted me since passage of the final Act—which as you know is more expansive and expensive than the Senate bill and it is mandatory.

Of this 20,000, not more than 10 have indicated their support.

And, Mr. Chairman, I can tell you, their concerns go far beyond merely the amount of money they are paying for the program. Their concerns really cut to the very core of the Act.

I believe the seniors of this country are generally very informed consumers. The fact that they are unhappy with the Act ought to be an indication that it misses the mark with regard to what their true catastrophic protection needs really are.

While I disagreed with the specifics of a proposal offered by our former distinguished colleague, Senator Claude Pepper, I think he was right when he said access to long-term care coverage is the greatest catastrophic illness concern of our nation's seniors. Indeed, that is consistent with what I have been hearing from my state's seniors, and it is consistent with the findings of the Wirthlin Group's poll. That poll found that 69% of the seniors would prefer something in the long-term care area over the benefits provided in the Act, while only 19% would prefer the Act over something in the way of long-term care coverage.

In saying this, I recognize that long-term care coverage is terribly expensive. I have heard some say that it will cost at least $50 billion to do something in the long-term care area. The bottom line is that we may not be able to do a comprehensive long-term care program at this time. Nonetheless, I believe that some sort of plan that helps make private plans more affordable and accessible to seniors, coupled with some direct public sector assistance would cost significantly less than $50 billion.

While it would be nice to develop a comprehensive public sector long-term care program, I think the expense prohibits us from doing so. The seniors realize this, and I think they are wondering why we spent so much on the benefits provided under the Act when long-term care is the more catastrophic and more costly of the seniors health care protection needs. I think their fear—a justifiable one at that—is that the existence of the Act makes it near impossible for us to offer anything meaningful in the way of long-term nursing home and home care assistance in the near future.

While the Act does provide some long-term care related benefits, such as long-term hospitalization, skilled nursing, spousal impoverishment protection, and coverage of home care following a hospitalization, it does not cover custodial care provided in the home or a nursing home. What's more, the passage of the Act—and the expense tied to it—may have prevented us from providing any assistance with long-term care coverage for a long time. The seniors recognize this. And, this has only fueled the fire of their discontent.

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[1] See material submitted by Thomas J. Kilcline.

Mr. Chairman, I believe we need to be asking ourselves the following question: What do the seniors believe are their most important catastrophic illness protection needs? And which of these areas can we reasonably address without sending the cost of any program out of sight?

It is not possible, Mr. Chairman, to provide public sector coverage of every health care need of our nation's elderly—especially given our current deficit problems. We must, therefore, work with the seniors to determine where they feel the public sector should be helping meet their health coverage needs. In my opinion, we need to provide seniors with protection from that which they cannot insure themselves against, and from that which is most costly and catastrophic. What they are telling me is that that which is most costly, and most catastrophic, and that they cannot protect themselves against is long-term custodial care.

It is an attempt to assist us in addressing these questions that I offered S. 335, the "Medicare Catastrophic Coverage Revision Act of 1989." This legislation, which has been sponsored by Senators Boren, Burns, Cochran, Domenici, Gorton, Hatch, Heflin, Hollings, McClure, McConnell, Pell, Roth, Shelby and Wilson; introduced by Congressmen DeFazio and Tauke; and has earned the endorsement of 40 national seniors organizations; would delay for a year implementation of those provisions in the Act that are not yet effective—with the exception of the "spousal impoverishment" benefit. Thus, the long-term hospitalization, skilled nursing facility and spousal impoverishment benefits would be protected for this year, while Congress would be afforded the opportunity to thoroughly reexamine the Act through public hearings.

Given the fact that seniors are both the purchasers and consumers under the Act, and the fact that they seem to be unhappy since learning of its specifics, I believe we have a responsibility to go back and take a second look. After all, the Act forces seniors to purchase a specific set of benefits, without regard to whether they want or need the benefits. I know that there are no easy answers to this problem, but based on what we now know it is imperative that we undertake this effort.

As I understand it, the focus of today's hearings is to be on what should be done with the supposed excess revenues collected under the Act.

Mr. Chairman, we must address several other questions. Such as, does the Act meet what the seniors see as their greatest catastrophic illness protection needs? And, if not, how should we go about reexamining the Act so that a determination might be made as to what changes ought to be made to the Act so that it more accurately reflects the senior's greatest needs?

But, with regard to the excess revenue issue, I would like to say a couple of things.

First, there seems to be great disagreement over whether we have actually collected excess revenues under the Act thus far. It seems to me that we must be very careful in looking at this so that we do not try to relieve the political heat we're feeling over the Act by reducing revenues to a level that will not support the long term viability of the benefit programs we established. Thus, we need to be very confident that the cost estimates for the benefits not yet in place are accurate. It seems that the costs of some of the benefits, such as the outpatient prescription drug benefit, are difficult at best to estimate accurately. The fact that the cost estimates of this program have varied all over the board, and have shifted dramatically since we adopted the Act is an' indication that the only way we are going to know true costs is when we pay for the benefits.

And, second, Mr. Chairman, I do not believe that simply modifying the premiums will quell the complaints of seniors. This is because I believe the firestorm has been caused by a frustration over not only the financing, but the Act's benefit package. Seniors strongly preferred the optional nature of the Senate bill rather than the final bill's mandatory participation, and they clearly believe the benefits we have required them to pay for are not the benefits they want the most. If we fail to see this, or if we try to avoid this by simply asking some one else to pay for the benefits, the seniors would see us as failing to recognize and listen to what their true concerns are regarding the Act.

What's more, from a policy perspective, Mr. Chairman, if we were to stay with the Act's current benefit structure, it seems imprudent to modify the financing or to even assume that there is a surplus before the most costly of the benefits are fully implemented.

In my opinion, these issues only further substantiate the need for us to thoroughly examine the Act, so that we might determine what, if any, changes ought to be made.

Again, I applaud you, Mr. Chairman, and members of the Committee, for your willingness to hold hearings to revisit the Act. But, I encourage you to make the revisiting effort a thorough examination of the entire Act, not just its financing.

Prepared Statement of H.T. Steve Morrissey

Mr. Chairman, I am H. T. Steve Morrissey, President of the National Association of Retired Federal Employees (NARFE).

On behalf of the over 2 million federal retirees and half-million members of NARFE, we appreciate this opportunity to present our views on an issue that has generated more concern, outrage and frustration among the nation's elderly than any other in our memory. We are particularly grateful that you are heeding the voice of the people and are taking another look at the new Medicare Catastrophic Law. We hope that this hearing represents the first of many to come. The complexity of this matter and the profound economic impact that the law will have on senior citizens demands that the issue be fully reevaluated.

Mr. Chairman, there is a prairie fire of protest against this new law that is spreading across this country. Visit any place where senior citizens gather and you will find that there is genuine outrage over P.L. 100-360, the Medicare Catastrophic Act. Check the mail from senior citizens in Congressional offices and you will surely discover that most of it is directed against this new measure. At our organization's national convention last fall, a resolution was unanimously adopted which describes the law's financing mechanism as a discriminating surtax for seniors only and calls for its elimination.

This rebellion was not manufactured by any interest group in Washington. Rather, it grew out of the grassroots feeling of millions upon millions of older Americans that this new law represents a new tax for acute health care benefits that most already have. Simply put, seniors are saying, it is a new tax and a bad buy.

We do not question the motives of the architects of the catastrophic law. We recognize a desire to address a real problem that does affect some senior citizens. However, to employ a medical metaphor, for many, the cure is worse than the disease.

In the case of the majority of federal retirees, Medicare catastrophic protection benefits are unnecessary. The Federal Employee Health Benefits Program (FEHBP) adequately covers annuitants for these expenses. These retirees gain little and pay dearly under the new law.

While we are grateful for Congress' action in attaching two amendments crucial to federal retiree interests during consideration of the legislation last year, they have not proved sufficient to quell the angry protests. The first amendment provided a special credit to reflect the fact that government annuities are taxable while social security benefits are largely not taxable. The second amendment sought to eliminate duplication of coverage between the FEHBP and Medicare. The new Medicare benefits that became effective January 1, 1989 for this year have resulted in a $3.10 per month rebate to federal retirees who have incurred this duplication of coverage. A recent report from the General Accounting Office (GAO) indicates that this rebate is accurate. But that does little to address the outrage of federal retirees. After all, they are already paying $4 extra dollars each month for Part B coverage and will soon be required to pay the surtax. This scenario further emphasizes and underscores their perception that they really are getting very little for the extra costs they will be required to shoulder.

Attached Exhibit I, shows the surtax computation for middle income federal annuitants, a single retiree, John C. and retired couple Fred and Wilma F. Exhibit II then uses these computed surtaxes to compare what Mr. C and Mr. and Mrs. F paid for health insurance with catastrophic protection in 1988, and what they will be required to pay for basically this same level of coverage in 1989. You will note that John C's yearly cost has risen 50 percent, from $654.60 last year to $980.64 this year. Fred and Wilma's insurance cost has gone up 35 percent, from $1286.16 to $1739.64.

Then for the sake of further comparison, Exhibit III illustrates the percentage increases had Mr. C. paid the maximum $800 surtax, and had John and Wilma paid the $1600 maximum surtax for a couple. At that level John's insurance costs would increase 135 percent from 1988 to 1989, and Fred and Wilma's 1989 costs would increase 142 percent.

And while this situation refers only to federal retirees, available data shows that in fact, only about 20 percent of the elderly population were without Medicare supplemental health insurance or Medigap policy. Fully 80 percent of the nation's senior citizens receive catastrophic insurance coverage through either their company sponsored retirement plans or private insurance policies. The mandatory nature of the Catastrophic law shifts that coverage and cost onto Medicare. In doing so, it creates a dependency on the federal government where none previously existed.

We are also troubled by news reports that perhaps the biggest casualty of the fallout over the Catastrophic law will be passage of long-term care legislation. We recognize, as you do, that any program to cover long term care will be costly. But we also know that long term health care coverage is what seniors want, not the expanded acute care coverage that most already have. The package of acute care benefits added to Medicare in P.L. 100-360 has been termed "catastrophic" coverage. But expenses for long term care at home and in nursing homes are those most apt to bankrupt individuals and are what the elderly fear most. Protection against long term care costs is what senior citizens view as "catastrophic" coverage. Seniors are well aware that they must share in the cost of long term care insurance, and we believe they are more than willing to do so. Yet, we also believe that this mandatory new acute care coverage has used up a huge portion of both the willingness and the resources they will need to pay for long term care protection.

We believe that a closer examination of the outcry of the elderly over the Catastrophic law will reveal two important conclusions:

(1) If the benefits provided in P.L. 100-360 were ones that senior citizens perceived they needed, the protests now flooding Congressional offices and senior organizations would be substantially reduced; and

(2) If it is established that expanded acute care benefits are warranted through Medicare as good social policy, then all who stand to share in those benefits should help pay for them.

NARFE is not now, and has never advocated, that these expanded benefits be fully funded through general revenues. Fiscal responsibility precludes consideration of such a recommendation. Nor have we advocated that the elderly should not share in the costs of such a program. However, we have a responsibility to insure that if only the elderly must pay, then they should have some choice in the matter and only be required to pay for benefits that the majority truly need.

We also recognize the need and responsibility to provide adequate acute care to those who are truly needy. But the cost of providing this coverage should be shared by all taxpayers through a system that assesses the cost fairly—not by a rapidly escalating surtax that imposes the highest income tax rates in the country on senior citizens.

The surtax which is set at 15 percent of tax liability for 1989, jumps to 25 percent in 1990. Twenty-five percent! A full one-fourth of middle income individual's or couple's total tax liability to the federal government for a whole year will be tacked on just to pay for the catastrophic benefits. One's federal income tax liability covers 6uch diverse services as the defense of our country, our space program, roads, schools and the many social programs deemed to be in the best interests of the nation.

It is alarming to realize that in just the second year of the Catastrophic law's effectiveness, the Medicare surtax is set to impose a full twenty five percent more to the federal tax liability of almost half our senior citizens.

Along these lines, the Chairman's recent comment that some reevaluation of surtax premiums might be possible was welcomed. However, simply discounting the surtax does not address the real problem which IS the surtax.

Mr. Chairman, the outcry against the Medicare surtax is not coming just from "wealthy" senior citizens. Despite popular rhetoric, the surtax burden on the truly wealthy is minimal. The annual maximum dollar premium results in a rapidly decreasing surtax percentage for them. In fact, it is the middle income elderly with limited tax shelters and deductions who suffer its effects the most. And they know it.

Exhibit IV is an illustration of this point. At just over $50,000 of taxable income in 1989, the surtax, as a percentage of taxable income, begins to decline. At $75,000 the percentage drops from 15 percent to 9.25 percent, and at $300,000 the surtax, as a percentage of taxable income, drops to 1.8 percent. We cite these facts to make the point that the wealthy are probably *not* the seniors who are complaining about the surtax because the wealthy are getting the best buy.

And, if the current surtax maximum is lowered, as has been suggested, it becomes even a better buy for the wealthy, but middle income seniors continue to bear the full percentage cost, as illustrated in Exhibit V.

In recent weeks, we have seen reports that the Congressional Budget Office (CBD) underestimated the revenues from the Catastrophic surtax, and that the Department of Health and Human Services (HHS) believes the cost of the prescription drug benefits has been severely underestimated. Thus, even before revenues from the surtax have begun to flow into the reserve trust fund, and more than a year before the outpatient prescription drug benefit becomes effective, estimates on which the law's funding and benefits were based are being questioned.

As you are perhaps aware, NARFE, along with The Retired Officers Association, was instrumental in setting up a coalition of some 40 organizations which seek full reevaluation of the Catastrophic law. This Coalition for Affordable Health Care evolved in response to concern voiced by millions of seniors that the Catastrophic law imposes a mandatory surtax on them but fails to provide coverage for what most believe is the real "catastrophe" they face—the cost of long term care.

While the various coalition organizations are not necessarily in full agreement on the best way to fix this unpopular law, there is universal agreement among the membership on two points: (1) That the present seniors only mandatory surtax method of financing the benefits is flawed; and, (2) That the law ignores the real catastrophe the elderly face which is long term nursing home and home health care.

A recent survey sponsored by the coalition supports these sentiments, and will be addressed in more detail by my colleague, Admiral Kilcline, in his testimony.

We believe that all these factors taken together warrant indeed demand full reevaluation of the Catastrophic law.

Toward this end, the coalition supports legislation introduced in both the House and Senate which we believe represents a sensible approach to these common concerns. S. 335 introduced by Senator John McCain (R-AZ) and HR 1564 introduced by Congressman Peter DeFazio (D-OR) are identical bills which place a one year moratorium on the surtax and on implementation of any further benefits after 1989, giving Congress time to hold additional hearings, reassess new cost and revenue estimates and determine the best course of action.

The law states that if costs exceed revenues beyond a certain point, benefits cutbacks will be mandated. With current estimates from a variety of sources already indicating that before long costs may in fact exceed previous estimates, it certainly seems that the responsible course of action is to study the situation now. A moratorium to permit a review of the entire package will be better received now, than will benefit reductions later.

Only through continued hearings like this one can the best course of action be determined. Without some relief, however, the wrath of the nation's elderly is unlikely to be diffused and is more apt, we believe, to intensify between now and next spring when the first surtax payments become due.

We appreciate this opportunity to testify today, and look forward to working with this Committee, the Congress, and other concerned groups to resolve how we can provide adequate acute care to the truly needy, and begin providing seniors with the long term care protection they truly need.

EXHIBIT I.—SURTAX COMPUTATION FOR FEDERAL ANNUITANTS—INDIVIDUAL AND COUPLE

John C.	
Gross income from annuity, etc	$20,000.00
Social Security	2,500.00
	22,500.00
Less exemption and standard deduction	5,700.00
	16,800.00
Less non-taxable social security	2,500.00
Taxable income	$14,300.00
Federal tax	$2,141.00
Surtax (minus government pension adjustment)	$242.40
Fred & Wilma F.	
Gross income from annuity, etc	$25,000.00
Social Security	4,000.00
	29,000.00
Less exemptions and standard deductions	10,100.00
	18,900.00
Less non-taxable social security	4,000.00
Taxable income	$14,900.00
Federal tax	$2,239.00

EXHIBIT I.—SURTAX COMPUTATION FOR FEDERAL ANNUITANTS—INDIVIDUAL AND COUPLE—Continued

Surtax (minus government pension adjustment)	$223.35

EXHIBIT II.—COST COMPARISON—1988 vs 1989

[This chart uses FEHB Blue Cross-Blue Shield standard option figures and the surtax information for John as an individual taxpayer, and Fred and Wilma as a couple. The surtax amounts are based on the taxable income figures in Exhibit I.]

	1988		1989	
	John	Fred & Wilma	John	Fred & Wilma
		MONTHLY COST		
BC-BS Standard	$29.75	$57.58	$32.72	$68.77
Part B	24.80	49.60	31.90	63.80
Surtax (15%)	.00	.00	20.20	18.60
Subtotal	54.55	107.18	84.82	151.17
FEHB Rebate	.00	.00	−3.10	−6.20
Total Cost	54.55	107.18	81.72	144.97
		YEARLY COST		
BC-BS Standard	$357.00	$690.96	$392.64	$825.24
Part B	297.60	595.20	382.80	765.60
Surtax (15%)	.00	.00	242.40	223.20
Subtotal	654.60	1,286.16	1,017.84	1,814.04
FEHB Rebate	.00	.00	−37.20	−74.40
Total Cost	654.60	1,286.16	980.64	1,739.64
Percentage Increase			50	35

EXHIBIT III.—COST COMPARISON—1988 vs 1989

[Monthly and yearly figures for individual and couple using FEHB Blue Cross–Blue Shield (BC-BS) standard option. Surtax used is ***maximum.***]

	1988		1989	
	Individual	Couple	Individual	Couple
		MONTHLY COST		
BC-BS Standard	$29.75	$57.58	$32.72	$68.77
Part B	24.80	49.60	31.90	63.80
Surtax (15%)	.00	.00	66.66	133.33
Subtotal	54.55	107.18	131.28	265.90
FEHB Rebate	.00	.00	−3.10	−6.20
Total Cost	54.55	107.18	128.18	259.70
		YEARLY COST		
BC-BS Standard	$357.00	$690.96	$392.64	$825.24
Part B	297.60	595.20	382.80	765.60
Surtax (15%)	.00	.00	800.00	1600.00
Subtotal	654.60	1,286.16	1,575.44	3,190.84
FEHB Rebate	.00	.00	−37.20	−74.40
Total Cost	654.60	1,286.16	1,538.24	3,116.44
Percentage increase			135	142

EXHIBIT IV.—THE SURTAX AS A PERCENTAGE OF TAXABLE INCOME

[Couples filing jointly]

Taxable Income Line 37, 1040[1]	Tax[1]	1989 surtax	1990 surtax	1989 surtax (percent)	1990 surtax (percent)
$15,000	$2,254	$338.10	$563.50	15.00	25.00
25,000	3,754	563.10	938.50	15.00	25.00
50,000	10,126	1,518.90	1,700.00	15.00	16.78
75,000	17,287	1,600.00	1,700.00	9.25	9.83
100,000	25,537	1,600.00	1,700.00	6.26	6.65
125,000	33,787	1,600.00	1,700.00	4.73	5.03
200,000	57,092	1,600.00	1,700.00	2.80	2.97
300,000	85,092	1,600.00	1,700.00	1.88	1.99

[1] Source: IRS Publication 17—1988 Tax Tables; 1988 Form 1040

EXHIBIT V.—EFFECT OF LOWERING CAP TO $600 FOR 1989

Taxable Income Line 37, 1040[1]	Tax[1]	1989 Surtax	1989 Surtax as percent of Taxable Income
$15,000	$2,254	$338.10	15.00
25,000	3,754	563.10	15.00
42,000	7,900	1185.00	15.00
50,000	10,126	1200.00	11.85
75,000	17,287	1200.00	6.94
100,000	25,537	1200.00	4.69
125,000	33,787	1200.00	3.55
200,000	57,092	1200.00	2.10
300,000	85,09	1200.00	1.41

[1] Source: IRS Publication 17—1988 Tax Tables; 1988 Form 1040.

PREPARED STATEMENT OF ROBERT J. MYERS

There have been some exceptions, but these were usually remedied in a short while. One instance was the 1977 legislation on the Old-Age, Survivors, and Disability Insurance program, which remedied a large portion, but by no means all, of the estimated long-range actuarial imbalance that was thought to be present at that time. (Although the Senate version of the bill did properly remedy this matter, the Conference Agreement did not do so.)

Another instance where inadequate long-range financing was not provided has been the continuing situation with regard to the Hospital Insurance program. For a number of years, a sizable long-range imbalance has been shown in the actuarial estimates. The cash-flow situation under HI for about the next 10 years appears to be satisfactory, but after that time, some change in the financing or the benefit structure would seem to be necessary. I recommend that, for the time being, the long-range imbalance situation should be remedied by revising the contribution schedule so that adequate financing on a pay-as-you-go basis is present.

FAIRNESS OF THE SUPPLEMENTAL PREMIUM

Many elderly are dissatisfied with the new Medicare Catastrophic Coverage program. But the question of whether it is inequitable is like the fable of the blind persons describing the elephant—it depends on what you examine.

The plan's aged and disabled participants are, in the aggregate, intended to pay the entire cost of the new benefit protection. Accordingly, what causes discord is the nature of averages—some (higher-income people) pay more than the added protection is worth, while others (lower-income people) pay less.

A special problem of equity arises for those with supplementary protection from post-retirement health plans established by employers—especially when such plans are comprehensive, and the employers pay most of the cost. Under such circumstances, individuals may end up paying much more for no more protection than they had before.

Considered in this way, the situation seems very inequitable to many Medicare participants. However, let us look at the "elephant" from another angle. About 95% elect coverage under Supplementary Medical Insurance—the program that mainly covers physician fees. This year, they receive a tax-free subsidy of $1,004 from the General Treasury (i.e., from taxpayers of all ages) amounting to about 2.6 times the SMI premium which they paid themselves. It is estimated that, in 1993, this tax-free payment will amount to $1,515.

The new plan requires a so-called Supplemental Premium to be paid by all people eligible for the Hospital Insurance portion of Medicare for more than six months in a calendar year if they had income-tax liability of at least $150. The supplemental Premium is a surcharge on the income-tax liability, which starts at 15% this year and reaches 28% in 1993. A per-capita limit is provided—beginning at $800 this year and reaching $1,050 in 1993. These limits apply roughly to single people with incomes of at least $30,000 and to married couples filing joint returns with incomes of at least $50,000.

Thus, high-income people will pay a substantial added charge which is not being asked of lower-income people. The additional benefit protection is worth far less than the additional premium

Let's examine the situation for high-income participants in 1993, when the new plan is first fully effective. The maximum Supplemental Premium will be $1,050 per year. In addition, the monthly Flat Premium rate for catastrophic benefits will rise to $10.20 (including a portion that pays part of the cost for the new Catastrophic Drug Insurance benefits).

Accordingly, premiums will increase by a maximum of $1,172.40. This additional expenditure for high-income people reduces (but does not eliminate) the tax-free subsidy of $1,515 mentioned previously. When viewed from this angle, high-income people are not, overall, being inequitably treated. Rather, most of the tax-free windfall they have received under the basic portion of SMI has been "taken back."

Thus, on the average, high-income people participating in Medicare will not have any "net" loss from their increased out-of-pocket costs. Such costs merely partially offset bonanzas from the General Treasury that are provided under the provisions of previous law. Such people cannot avoid most of the new, increased premium costs. If they drop out of SMI and CDI (to avoid paying the monthly Flat Premium), they must still pay the annual Supplemental Premium (and not receive SMI and CDI benefits that are partially financed by a portion of it).

Although high-income people without employer-paid supplementary health insurance "lose" most of the government subsidy they had received for many years, they do have increased catastrophic benefit protection. Still, these people will probably be convinced that they are being inadequately treated when a bonanza they have had for years is partially taken away!

COMPLEXITY OF FINANCING OF CATASTROPHIC COVERAGE ACT

The new legislation contains financing provisions for the two previous parts of Medicare—Hospital Insurance and Supplementary Medical Insurance and for the new Catastrophic Drug Insurance portion. These provisions are very complex and difficult to follow. The new Supplemental Premium (based on the income tax liability of the enrollee) is divided among all three portions of Medicare. The Additional Flat Premium is divided up between SMI and CDI. Furthermore, three new funds or accounts are created—the CDI Trust Fund, the Medicare Catastrophic Coverage Account, and the HI Catastrophic Coverage Reserve Fund. Quite anomalously, the last-mentioned has a flow of income into it, but no disbursements therefrom are provided! The next-to-last one is a purely paper, or bookkeeping, account.

The accompanying chart shows graphically the flow of funds for the financing of the new benefits provided under the 1988 legislation. Under the proposal that I am about to make, the latter two funds would be eliminated.

PROPOSAL TO REVAMP THE FINANCING OF THE CATASTROPHIC COVERAGE ACT

I believe that the financing provided under the 1988 legislation can be restructured so that it is more equitable and is easier to understand, while at the same time making certain relatively small changes in the benefit provisions. The latter changes would be made so as to de-emphasize slightly the first-dollar aspects of the Medicare program, and should not impose significant financial burdens on the enrollees. At the same time, my proposal would maintain the basic financing principle of the legislation—namely, that the cost in the aggregate should be borne by the enrollees and should not be passed on to younger persons.

It should be recognized that the Medicare program has never been financed on the basis that each individual receives benefit protection that is equal to what he or she contributes. For example, it has always been the case under the HI program that high-paid individuals contributed much more than the lower-paid ones, and yet the benefit protection is identical. Similarly, under SMI, although the portion paid by the enrollees through their premiums was the same for all persons, the portion of the financing coming from General Revenues falls much more heavily on higher-income persons than on lower-income ones.

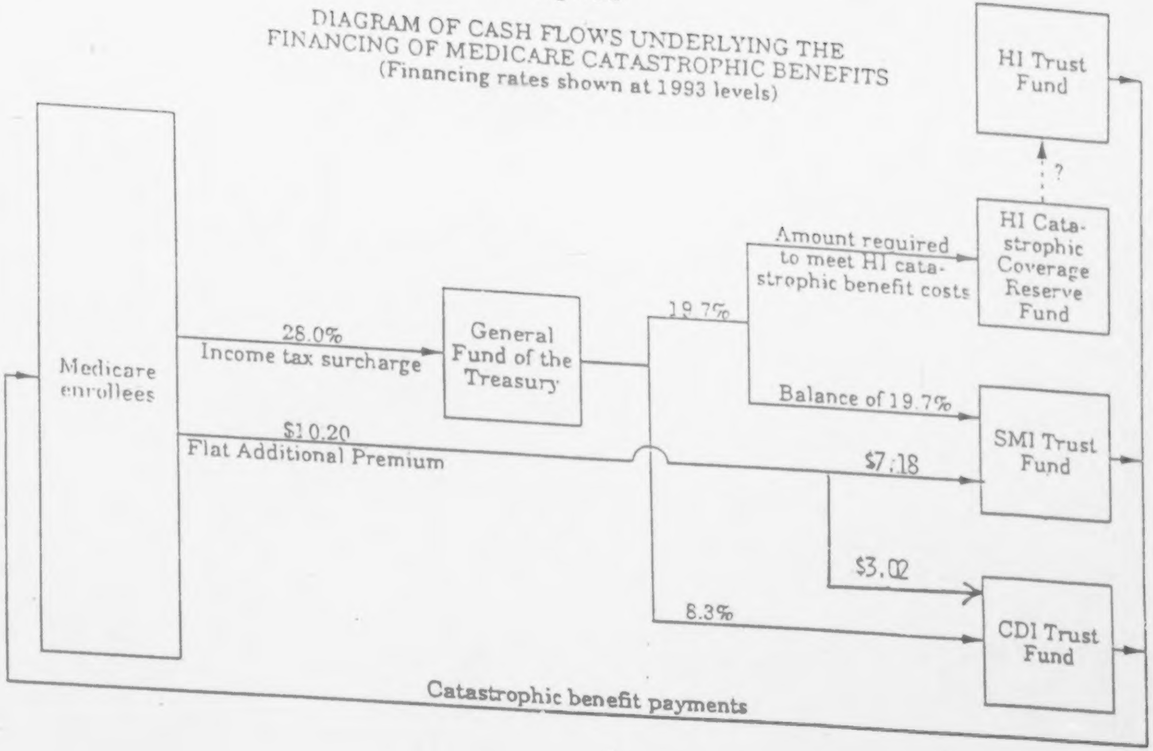
I believe that the HI program should be revised so that daily coinsurance equal to 5% of the annual initial deductible should be introduced for the second through the ninth days. Based on the initial deductible of $560 in 1989, this coinsurance would amount to $28 per day for a maximum of eight days. I estimate that this financing would meet all of the cost of the liberalization made by the 1988 legislation i.e., the payment of no more than one initial deductible annually and the elimination of daily coinsurance for hospitalization beyond 60 days. Thus, no additional financing for HI would be needed from either the Supplemental Premium or the Additional Flat Premium.

Next, turning to the SMI program, I recommend raising the annual deductible from $75 to $150 for 1990, and then indexing the amount for future years on the basis in the Consumer Price Index (either the overall one, or that based on physician fees).

Finally, I believe that the CDI program should be financed by a combination of an Additional Flat Premium and a Supplemental Premium based on the individual's income-tax liability. The latter will, of course, be at a much lower rate (and with a much lower maximum amount) than in the 1988 legislation, because it will finance only a portion of the CDI program, rather than part of all three portions of Medicare. At the same time, the notch that is now present in the Supplemental Premium—such that individuals born on a certain day pay the full annual premium, while those born one day later pay nothing for that year—would be eliminated. This can readily be done, both legislatively and administratively, by providing for pro rata premiums for the initial and final years of benefit coverage. By doing so, we will not have Medicare "Notch Babies" in addition to the Social Security Notch Babies already in existence.

Figure 1

DIAGRAM OF CASH FLOWS UNDERLYING THE FINANCING OF MEDICARE CATASTROPHIC BENEFITS
(Financing rates shown at 1993 levels)


Medicare enrollees
28.0%
Income tax surcharge
General Fund of the Treasury
$10.20
Flat Additional Premium
19.7%
Amount required to meet HI catastrophic benefit costs
Balance of 19.7%
$7.18
$3.02
8.3%
HI Trust Fund
?
HI Catastrophic Coverage Reserve Fund
SMI Trust Fund
CDI Trust Fund
Catastrophic benefit payments

PREPARED STATEMENT OF SENATOR DON NICKLES

Mr. Chairman, I appreciate the opportunity to participate in today's hearing on this very important issue. Events of the past months since the page of the Medicare Catastrophic Coverage Act of 1988 have illustrated overwhelming need for this hearing and I am pleased not only to see it happen but also to be a part of it. Further, I am hopeful this hearing will be constructive and will bring into focus some of the problems of this law.

In the one year since this legislation passed—with only 11 Senators dissenting—my office has been inundated with calls, letters, and postcards from seniors who have already realized how expensive this bill is for them. At last count, I have heard from 10,000 Oklahomans on this one issue alone, and the letters keep flowing in.

I have been back to my State many times since passage of the Catastrophic law. At every stop, every meeting, I have heard complaints about the tax surcharge this law creates. I hear that seniors already had similar coverage as that created by this law through the private sector. With the passage of this law, they now have a duplication of coverage and are paying double premium payments because they are afraid to cancel their privately provided insurance plans. The citizens of my State are upset that Congress voted such a massive tax burden on them. I am sure other Members have heard the same thing.

Throughout consideration of this legislation, statistics were continually mentioned as to what percentage of Medicare recipients would actually benefit from the expansion. The overwhelming majority of senior citizens already had private coverage. Further, most seniors would never even use the expanded benefits. Congress mandated a service to few at an onerous cost to many. That's not fair, and that's not what we should be doing.

There are those who will need Catastrophic Coverage who do not have it. There are those who cannot afford to provide for themselves in the private sector. Those are the people we should target with legislation. We should not penalize those who saved all their lives to be able to protect themselves. Further, we should not penalize those who earned these health benefits as part of their retirement package who must now pay for their coverage. Let them continue with their private coverage. Let us do away with the mandated duplication of coverage for those who already have it. Let the Government provide coverage to those who need it and who cannot afford it.

I am encouraged by the willingness of this Committee to take another look at the Medicare Catastrophic Coverage Act of 1988. I am hopeful this law can be changed so that it is not such an expensive program.

Additionally, I look forward to hearing the witnesses' comments on this law almost a year to the day after it was passed. I am interested to hear what kinds of reactions other Members have heard from their States and whether they feel, as I do, that change is in order.

Thank you, Mr. Chairman.

POST CATASTROPHIC TOTAL COSTS FOR INDIVIDUALS—CALENDAR YEAR 1989

Tax liability	For couples ($1600 cap)	CY 1989 catastrophic supplemental premium	CY 1989 catastrophic flat premium (doubled for couples ($96))	CY 1989 total catastrophic premium	Total catastrophic premium (couples)	Existing Medicare flat premium (doubled for couples ($669.60))	CY 1989 total premium	CY 1989 total premium (couples)
$0		$0.00	$48.00	$48.00	$96.00	$334.80	$382.80	$765.60
0		0.00	48.00	48.00	96.00	334.80	382.80	765.60
90		0.00	48.00	48.00	96.00	334.80	382.80	765.60
225		33.75	48.00	81.75	129.75	334.80	416.55	799.35
900		135.00	48.00	183.00	231.00	334.80	517.80	900.60
1,575		236.25	48.00	284.25	332.25	334.80	619.05	1001.85
2,250		337.50	48.00	385.50	433.50	334.80	720.30	1103.10
2,737		410.55	48.00	458.55	506.55	334.80	793.35	1176.15
3,150		472.50	48.00	520.50	568.50	334.80	855.30	1238.10
3,665		549.75	48.00	597.75	645.75	334.80	932.55	1315.35
4,181		627.15	48.00	675.15	723.15	334.80	1009.95	1392.75
5,652	$847.80	800.00	48.00	848.00	943.80	334.80	1182.80	1613.40
6,982	1047.30	800.00	48.00	848.00	1143.30	334.80	1182.80	1812.90

POST CATASTROPHIC TOTAL COSTS FOR INDIVIDUALS—CALENDAR YEAR 1989—Continued

Tax liability	For couples ($1600 cap)	CY 1989 catastrophic supplemental premium	CY 1989 catastrophic flat premium (doubled for couples ($96))	CY 1989 total catastrophic premium	Total catastrophic premium (couples)	Existing Medicare flat premium (doubled for couples ($669.60))	CY 1989 total premium	CY 1989 total premium (couples)
8,312	1246.80	800.00	48.00	848.00	1342.80	334.80	1182.80	$2012.40

POST CATASTROPHIC TOTAL COSTS FOR INDIVIDUALS—CALENDAR YEAR 1990

Tax liability	For couples ($1700 cap)	CY 1990 catastrophic supplemental premium	CY 1990 catastrophic flat premium (doubled for couples ($117.60))	CY 1990 total catastrophic premium	Total catastrophic premium (couples)	Existing Medicare flat premium	CY 1990 total premium	CY 1990 total premium (couples)
$0	....	$0.00	458.80	$58.00	$117.60	$348.00	$406.80	$813.60
0	....	0.00	58.80	58.00	117.60	348.00	406.80	813.60
90	....	0.00	58.80	58.00	117.60	348.00	406.80	813.60
225	....	56.25	58.80	115.05	173.85	348.00	463.05	869.85
900	....	225.00	58.00	283.80	342.60	348.00	631.80	1038.60
1,575	....	393.75	58.80	452.55	511.35	348.00	800.55	1207.35
2,250	....	562.50	58.80	621.30	680.10	348.00	969.30	1376.10
2,737	....	684.25	58.80	743.05	801.85	348.00	1091.05	1497.85
3,150	....	787.50	58.80	846.30	905.10	348.00	1194.30	1601.10
3,665	916.75	850.00	58.80	908.80	1033.85	348.00	1256.80	1729.85
4,181	1045.75	850.00	58.80	908.80	1162.85	348.00	1256.80	1858.85
5,652	1413.00	850.00	58.80	908.80	1530.60	348.00	1256.80	2226.60
6,982	1700.00	850.00	58.80	908.80	1817.60	348.00	1256.80	2513.60
8,312	1700.00	850.00	58.80	908.80	1817.60	348.00	1256.80	2513.60

POST CATASTROPHIC TOTAL COSTS FOR INDIVIDUALS—CALENDAR YEAR 1993

Tax liability	For couples ($2100 cap)	CKY 1993 catastrophic supplemental premium	CY 1993 catastrophic flat premium (doubled for couples ($244.80))	CY 1993 total catastrophic premium	Total catastrophic premium (couples)	Existing Medicare flat premium (doubled for couples ($801.60))	CY 1993 total premium	CY 1993 total premium (couples)
$0	....	$0.00	$122.40	$122.40	$244.80	$400.80	$523.20	$1046.40
0	....	0.00	122.40	122.40	244.80	400.80	523.20	1046.40
90	....	0.00	122.40	122.40	244.80	400.80	523.20	1046.40
225	....	63.00	122.40	185.40	307.80	400.80	586.20	1109.40
900	....	252.00	122.40	374.40	496.80	400.80	775.20	1298.40
1,575	....	441.00	122.40	563.40	685.80	400.80	964.20	1487.40
2,250	....	630.00	122.40	752.40	874.80	400.80	1153.20	1676.40
2,737	....	756.36	122.40	888.40	1101.16	400.80	1289.56	1812.76
3,150	....	882.00	122.40	1004.40	1126.80	400.80	1405.20	1928.40
3,665	....	1026.00	122.40	1148.40	1270.80	400.80	1549.20	2072.40
4,181	1170.68	1050.00	122.40	172.40	1415.48	400.80	1573.20	2217.08
5,652	1587.56	1050.00	122.40	1172.40	1827.36	400.80	1573.20	$2628.96
6,982	1954.96	1050.00	122.40	1172.40	2199.76	400.80	1573.20	3001.36
8,312	2100.00	1050.00	122.40	1172.40	2344.80	400.80	1573.20	3146.40

Prepared Statement of Ronald A. Pearlman

OVERVIEW OF PRESENT LAW AND ESTIMATED BUDGET EFFECTS OF THE MEDICARE CATASTROPHIC INSURANCE PROGRAM AND DESCRIPTION OF POSSIBLE PREMIUM OPTIONS (PREPARED BY THE STAFF OF THE JOINT COMMITTEE ON TAXATION)

INTRODUCTION

The Senate Committee on Finance has scheduled a hearing on June 1, 1989, on the estimated budget effects of the Medicare catastrophic insurance program and supplemental premium options under the Medicare Catastrophic Coverage Act of 1988.

This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a discussion of present law, estimated budget effects, distribution of the supplemental premium, and possible premium options.

Part I of the document provides a summary description of present law relating to Medicare benefits and financing of the benefits. Part II compares the estimated budget effects of the Medicare catastrophic insurance program when the Act was enacted and the current estimates by the Congressional Budget Office and the Administration. Part III provides data on the distribution of the current Medicare supplemental premium by income group, and Part IV discusses possible options to modify the premium. Finally, the Appendix describes the method for deriving the distributional estimates.

I. PRESENT LAW

A. MEDICARE BENEFITS

In general

Medicare is a nationwide health insurance program for the aged and certain disabled persons. Medicare consists of three parts: the hospital insurance program (Part A), the supplementary medical insurance program of Part B (SMI), and the catastrophic drug insurance program of Part B (CDI).

Individuals who have attained age 65 and who are eligible for monthly social security or railroad retirement benefits are covered under Part A of Medicare at no cost. Part A coverage is also available at no cost to certain disabled individuals who have not attained age 65 and to persons who have end-stage renal disease. Persons who have attained age 65 and who are not eligible for social security or railroad retirement benefits may obtain Part A coverage providing they pay for the coverage. The monthly premium for such coverage, as of January 1, 1389, is $156.

Within limits, Part A of Medicare provides coverage for inpatient hospital care, skilled nursing facility (SNF) care, home health care, and hospice care.

Coverage under Part B, which includes the SMI and the CDI programs, is voluntary. All persons age 65 or older and individuals eligible for Part A benefits by virtue of disability or end-stage renal disease may elect to enroll in both these programs by paying the monthly premium. Enrollees may not elect to enroll in only one of these programs.

SMI covers doctor's services, other medical and health services (e.g., laboratory and other diagnostic tests, ambulance services, outpatient services at a hospital), and certain home health services not covered under Part A. SMI covers 80 percent of the reasonable charges for such services, subject to a deductible. Beginning in 1990, enrollees in Part B will also be eligible for prescription drug benefits.

Benefits under the Medicare Catastrophic Act of 1988

The Medicare Catastrophic Act of 1988 ("the Act") significantly expanded the benefits covered by Medicare. Major changes to the benefits are described below.

Part A benefits

Inpatient hospital care.—Under the Act, Medicare pays all hospital inpatient costs above an annual deductible amount ($560 for 1989). Under prior law, the number of days covered by Medicare was limited for a single spell of illness, covered individuals paid a deductible for each spell of illness, and coinsurance amounts were payable after the 60th day in each spell of illness. The Act eliminated the concept of a spell of illness, which began with a hospital admission and ended on the 61st day following discharge from the hospital or from a skilled nursing facility (SNF) entered after the hospital stay.

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[1] This document may be cited as follows: Joint Committee on Taxation, *Overview of Present Law and Estimated Budget Effects of the Medicare Catastrophic Insurance Program and Description of Possible Premium Options* (JCX-9-89), May 25, 1989.

Skilled nursing facility care.—Under the Act, the limit on SNF care is 150 days per year, and no prior inpatient stay is required for coverage. Coinsurance payments are required for the first 8 days of care each year, at a rate of 20 percent of average SNF costs per day ($25.50 for 1989). Under prior law, the limit on SNF care was 100 days per spell of illness, after a hospital stay of at least 3 days. Coinsurance payments were required for days 21 through 100 at a rate of 1/8th of the deductible amount ($67.50 for 1988).

Home health care.—Under prior law and the Act, there is no limit on the overall number of covered home health care visits and no coinsurance requirement. To be covered, home health care visits must be required on an intermittent basis. Under prior law, the intermittent requirement was interpreted to mean that there could be 5 to 7 visits a week, for 2 to 3 consecutive weeks. Under the Act, beginning in 1990, covered individuals may receive up to 38 consecutive days of home health care, 7 days a week.

Hospice care.—The Act eliminated the 210-day lifetime limit on hospice care.

Part B benefits

SMI benefits.—Beginning in 1990, the Act expands Part B benefits as follows. Each enrollee's annual liability for Part B copayments is capped. The cap is $1,370 for 1990, and will be adjusted each year to keep the proportion of enrollees subject to the cap constant at 7 percent. Part B coverage is expanded to include mammography screening for women, subject to a maximum of $50 (indexed) per screening and the usual copayment requirements. In addition, once sufficient costs have been incurred to receive benefits under either the copayment cap or the new drug provisions (see below), enrollees are eligible for respite benefits. Under this benefit, Medicare will pay 50 percent of reasonable costs for up to 80 hours a year of in-home personal services, to give the usual caretakers of homebound enrollees a respite.

Catastrophic drug insurance.—Effective January 1990, the Act provides coverage for drugs administered intravenously at home and for immunosuppressive drugs after the first year following a transplant, subject to an annual deductible amount of $550. Coinsurance of 20 percent will be required on drugs administered intravenously, while coinsurance will initially be 50 percent for newly-covered immunosuppressive drugs. (Medicare already covers 80 percent of the costs of immunosuppressive drugs in the first year following an organ transplant.)

Effective January 1991, the CDI program will be expanded. Coverage will include all outpatient prescription drugs and insulin, subject to an annual deductible amount ($600 in 1991) that will be adjusted each year to keep the proportion of enrollees paying the maximum deductible constant at 16.8 percent. Coinsurance requirements will be 50 percent of reasonable charges above the deductible in 1991, 40 percent in 1992, and 20 percent in 1993 and subsequent years.

B. FINANCING OF MEDICARE BENEFITS

Part A benefits

Part A benefits are financed through the Hospital Insurance Trust Fund. This trust fund is financed primarily through payroll tax contributions paid by employers, employees, and the self-employed. The payroll tax rate for 1989 is 1.45 percent of compensation up to $48,000 per employee. An equal amount is paid by the employer. Self-employed individuals pay both the employers' and employees' portion of the tax.

SMI benefits

SMI benefits are funded through the Supplementary Medical Insurance Trust Fund (SMI Trust Fund) by premiums paid by enrollees in the Part B program and general revenues. In 1989 a temporary provision requires that enrollee premiums provide 25 percent of the financing of Part B. Thereafter, premium rates will be derived annually based upon the projected costs of the program for the coming year, but premium increases will be limited to increases in the social security cost-of-living adjustment. Therefore, the share of benefits financed by premiums is expected to drop below 25 percent, while the general revenue share will grow. The basic Part B monthly premium for 1989 is $27.90, without regard to the additional premium added by the Act (see below).

Financing of benefits under the Medicare Catastrophic Coverage Act of 1988

In general

The new benefits provided by the Act are financed through the combination of (1) an increase in the Part B flat monthly premium and (2) a new supplemental premium based on income tax liability. It is anticipated that the supplemental. premium will finance approximately 63 percent of the costs under the Act, and that the flat premium will finance the remaining 37 percent of costs.

Flat premium

The Act provides for increases in the monthly Part B premium otherwise determined to finance the catastrophic coverage benefit and the prescription drug benefit. Through 1993, the amount of the increase is set by law. After 1993, the flat premium is adjusted through use of a formula that is designed to maintain a reserve in the Catastrophic Coverage Account and the CDI Trust Fund (see below).

For 1989-1993, the additional flat monthly premium for Part B enrollees is as follows:[2]

Year	Catastrophic Coverage Premium	Prescription Drug Premium	Total Catastrophic Flat Premium
1989	$4.00	$0.00	$4.00
1990	4.90	0.00	4.90
1991	5.46	1.94	7.40
1992	6.75	2.45	9.20
1993	7.18	3.02	10.20

Supplemental premium

The supplemental premium is payable in a year by any individual who is eligible for Part A of Medicare for at least 6 months during the year (except for those who pay the Part A premium), who has income tax liability for the year of at least $150, and who resides in one of the 50 states or the District of Columbia. Subject to a limit on the maximum premium payable by an individual, the annual premium is determined by multiplying (1) the supplemental premium rate by (2) the amount determined by dividing the individual's adjusted income tax liability by $150.

For years 1989 through 1993, the supplemental premium rate is set by law. For years after 1993, the supplemental premium rate is adjusted by a formula that is designed to maintain a reserve in the Catastrophic Coverage Account and the CDI Trust Fund (described below).

The supplemental premium rate is equal to the sum of the catastrophic coverage premium rate and the prescription drug premium rate as follows:

Year	Catastrophic Coverage Premium	Prescription Drug Premium	Total Supplemental Premium	Total Percent Rate [3]
1989	$22.50	$0.00	$22.50	15
1990	27.14	10.36	37.50	25
1991	30.17	8.83	39.10	26
1992	30.55	9.95	40.50	27
1993	29.55	12.45	42.00	28

[3] This column shows the total supplemental premium as a percent of tax liability.

The maximum annual supplemental premium shall not exceed the following amount:

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[2] Residents of Puerto Rico, other U.S. commonwealths or territories, and individuals not entitled to or eligible for Medicare Part A have different premium schedules.

In the case of taxable years beginning in:	The limitation is:
1989	$800
1990	850
1991	900
1992	950
1993	1,050

For years after 1993, the cap on the maximum supplemental premium is increased through the use of a formula (see below).

Married individuals who both are eligible for Part A benefits for at least 6 months during the year are treated as a single individual for purposes of the supplemental premium, except that the maximum limit on the supplemental premium is doubled (e.g., $1,600 for 1989). If only one spouse is Medicare-eligible for 6 months of the year, income tax liability is determined as one-half of the tax liability of the joint return.

In the case of married individuals filing separate returns, the individual is treated as Medicare-eligible for 6 months if either the individual or the individual's spouse is so eligible. In addition, the maximum supplemental premium is twice the supplemental premium if, without regard to the rule in the preceding sentence, both spouses are Medicare eligible for 6 months of the year. This provision is designed to prevent the supplemental premium from creating an incentive for married taxpayers to file separate returns.

Accounting

The receipts from the catastrophic coverage supplemental and monthly premiums fund the health and supplementary medical insurance portions of the catastrophic benefit (i.e., the increases in Part A and SMI benefits). The receipts from the prescription drug supplemental and monthly premiums fund the prescription drug benefits. These two sources of receipts and benefits are accounted for separately.

The prescription drug benefits are funded by the Catastrophic Drug Insurance Trust Fund (the "CDI Trust Fund"). All receipts attributable to the drug portion of the premiums are placed into the CDI Trust Fund and all payments for the benefits and administrative costs relating to covered drugs are drawn from the CDI Trust Fund.

Receipts attributable to the monthly flat catastrophic coverage premium are allocated to the SMI Trust Fund. Receipts attributable to the supplemental catastrophic coverage premium are allocated to the SMI Trust Fund and a newly created Federal Hospital Insurance Catastrophic Reserve Fund, with the division determined by the outlays from the catastrophic hospital insurance program. Outlays for catastrophic coverage are made from the Part A Hospital Insurance Trust Fund and the SMI Trust Fund.

In order to account for the receipts and outlays of the catastrophic coverage program separately from the prescription drug program, a bookkeeping account, known as the Medicare Catastrophic Coverage Account (the "Catastrophic Coverage Account"), was created. The balance recorded in the Catastrophic Coverage Account represents the cumulative financial position of the catastrophic coverage program.

The Catastrophic Coverage Account is used to calculate monthly and supplemental catastrophic coverage premium rates after 1993 in a manner intended to maintain a contingency reserve in the Catastrophic Coverage Account. Similar adjustments are made after 1993 to the monthly and supplemental prescription drug premiums based on the balance in the CDI Trust Fund.

Adjustments to premiums after 1993

After 1993, the monthly and supplemental premiums and the supplemental premium cap are adjusted through the use of a formula. The formula is designed to maintain a reserve equal to 20 percent of annual outlays in the Catastrophic Coverage Account and, by 1996, a reserve in the CDI Trust Fund of 20 percent of annual outlays. The catastrophic coverage supplemental premium is adjusted by a percentage reflecting the past growth of per capita Medicare catastrophic coverage outlays relative to premiums paid, recent inflation, and the excess or shortfall of the balance in the Catastrophic Coverage Account of 20 percent of annual outlays in a preceding year. Similar calculations are performed for the prescription drug Supplemental premium rate based on the balance in the CDI Trust Fund. In no case may the total supplemental premium rate increase over the prior year's premium by more than $1.50 or one percentage point of tax liability. The premium may not decrease under the formula.

Adjustments in the maximum supplemental premium cap after 1993 are based on the relative per capita growth of Part B outlays to Part B premiums in preceding years. The cap will be rounded to the nearest $50.

The formula for adjustments in the monthly premium, after 1993, is similar to the formula used for the supplemental premium. The Congress intended that the monthly premium continue to provide 37 percent of the revenues for the catastrophic program and the supplemental premium is to provide 63 percent of such revenues, however, the proportion could vary as a result of limits on allowable change in the supplemental premium. If the change in the supplemental premium rate as calculated by formula is limited by the restrictions on annual increases or decreases, then the change in the monthly premium is designed, with certain adjustments, to account for any excess or shortfall.

II. BUDGET EFFECTS OF MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

A. CATASTROPHIC RESERVE FUNDS BALANCES

Congress intended, in the Medicare Catastrophic Coverage Act of 1988, to maintain a surplus of funds to pay for benefits covered under the Act. As described above, the record keeping of these reserve funds is accomplished through the Medicare Catastrophic Coverage Account and the Catastrophic Drug Insurance Trust Fund.

Table I presents estimates of the calendar year-end balances in the Catastrophic Coverage Account and the CDI Trust Fund that were made upon enactment of the Act, and estimates based on the current Congressional Budget Office (CBO) baseline.[4] The estimates made upon enactment indicate a calendar year 1993 year-end balance in the Catastrophic Coverage Account of $1.6 billion and of $1.7 billion in the CDI Trust Fund. As a percentage of calendar year 1993 outlays, these balances are 20.5 percent in the Catastrophic Coverage Account and 57.6 percent in the CDI Trust Fund.

The current CBO estimates of the balances in the Catastrophic Coverage Account and the CDI Trust Fund at calendar 1993 year-end are $5.7 billion and $2.3 billion, respectively. As a percentage of calendar year 1993 outlays, the balance in the Catastrophic Coverage Account is projected to be 71.9 percent and the balance in the CDI Trust Fund is projected to be 76.9 percent. The February 1989 CBO estimate of the calendar 1993 year-end combined balance is $8.0 billion, which is $4.7 billion more than the combined balance of $3.3 billion estimated upon enactment.

B. RECEIPT AND OUTLAY EFFECTS

In order to generate contingency reserves in the Catastrophic Coverage Account and CDI Trust Fund, it is generally necessary for cumulative receipts to exceed outlays. The cumulative excess of receipts over outlays will not match the combined balance of the Catastrophic Coverage Account and the CDI Trust Fund reserve amounts due to credits and debits of interest and the difference in the timing of receipts and outlays between fiscal and calendar years.[5]

Table 2 presents estimates prepared by CBO for the February 1989 budget baseline of 1989 through 1993 fiscal year receipts and outlays of the Medicare catastrophic program. For comparison, Table 2 also presents corresponding estimates of the program prepared by CBO and the Joint Committee on Taxation at the time of enactment of the Act and Administration estimates from the Fiscal Year 1990 Budget.

The cumulative excess of receipts over outlays for fiscal years 1989 through 1993 is $8.0 billion according to the current CBO estimate. This recent estimate exceeds by $3.8 billion the estimate of the cumulative excess of $4.2 billion made upon enactment.

The Administration estimates that the cumulative excess of receipts over outlays for fiscal year 1989 through 1993 is $6.2 billion. This total is $1.8 billion less than the current CBO estimate, but $2.0 billion more than the CBO estimate upon enactment. The Administration estimates, however, that the CDI Trust Fund will have insufficient funds to make all benefit payments in 1992 and, thus, will not make payments for eligible drug benefits for calendar year 1993.

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[4] The current CBO estimates reported in Tables 1 and 2 differ from the amounts used in the February 1989 budget baseline. The estimates in the tables include expected outlay amounts for the administration of the drug benefit that have not yet been appropriated and, thus, are excluded from the baseline used for budget purposes. Estimates that include the expected outlays necessary for the administration of the drug benefit may reflect more accurately the total budget effect of the Act and are also consistent with the estimates made upon enactment.

[5] Both the Catastrophic Coverage Account and the CDI Trust Fund are credited with interest in periods for which they are in surplus, and debited for interest when in deficit.

The Administration estimates of receipts from the monthly and supplemental premiums and outlays for the hospital and supplemental medical insurance and the catastrophic drug benefit are all different from the current CBO estimate. The Administration estimates that the level of cumulative receipts from the supplemental premium over fiscal years 1989 through 1993 are greater than that of the current CBO estimate. Much larger outlay estimates by the Administration, particularly for the drug benefit program, however, more than offset the Administration's higher receipts estimates over the period.

TABLE 1.—CURRENT CONGRESSIONAL BUDGET OFFICE ESTIMATE OF MEDICARE CATASTROPHIC ACCOUNT AND DRUG TRUST FUND EFFECTS, END OF CALENDAR YEARS 1989–1993

[Billions of dollars]

	1989	1990	1991	1992	1993
Final Estimate Enactment					
Catastrophic Account:[1]					
End-of-year balance	0.1	1.0	0.9	1.3	1.6
Balance/same year's outlays (in percent)	4.4	20.2	14.9	19.1	20.5
Drug Trust Fund:[2]					
End-of-year balance	0.0	0.2	1.2	1.6	1.7
Balance/same year's outlays (in percent)		149.4	99.0	74.9	57.6
Current CBO Estimate					
Catastrophic Account:[1]					
End-of-Year balance	0.3	2.5	3.3	4.6	5.7
Balance/same year's outlay (in percent)	17.3	51.0	54.2	67.1	71.9
Drug Trust Fund[2]					
End-of-year balance	0.0	0.3	1.5	2.0	2.3
Balance/same year's outlays		174.4	118.1	92.1	76.9

[1] The Medicare Catastrophic Coverage Account covers the hospital insurance and supplemental medical insurance portions of the Medicare catastrophic program.

[2] Administrative expenses for the Federal Catastrophic Drug Insurance Trust Fund have not been appropriated, so they are not included in the CBO baseline. Estimates of the Drug Trust Fund administrative expenses are included in this table for purposes of comparison.

TABLE 2.—ESTIMATES OF MEDICARE CATASTROPHIC BUDGET EFFECTS, FISCAL YEARS 1989–1993[1]

[Billions of dollars]

	1989	1990	1991	1992	1993	1989–1993
Estimate Upon Enactment:						
Supplemental premium receipts	−0.3	−4.2	−4.9	−5.7	−6.5	−21.7
Flat premium receipts	−1.1	−1.8	−2.7	−3.6	−4.1	−13.3
Outlays	1.3	4.2	6.7	8.4	10.1	30.8
Net budget effect	−0.1	−1.8	−1.0	−0.8	−0.5	−4.2
Current CBO Estimate:						
Supplemental premium receipts	−0.4	−5.4	−6.1	−6.7	−7.3	−25.9
Flat premium receipts	−1.2	−1.8	−2.7	−3.6	−4.1	−13.5
Outlays	1.3	4.2	6.8	8.7	10.5	31.4
Net budget effect	−0.3	−3.1	−2.0	−1.6	−1.0	−8.0
Administration Estimate:[2]						
Supplemental premium receipts	−0.6	−6.5	−7.1	−6.9	−7.3	−28.3
Flat premium receipts	−1.2	−1.8	−2.7	−3.6	−4.1	−13.4
Outlays	1.2	4.0	7.8	11.3	11.2	35.5
Net budget effect	−0.5	−4.4	−2.0	0.9	−0.2	−6.2

[1] These estimates are for the hospital insurance, supplemental medical insurance, and drug benefit programs of the Medicare Catastrophic Act of 1988. Provisions relating to Medicaid and other miscellaneous provisions of the Medicare Catastrophic Act are not included here. Estimates include unappropriated funds for the administration of the CDI Trust Fund. Totals may not add exactly due to rounding.

[2] Administration estimates are from the Fiscal Year 1990 budget. The Administration estimates that there will be insufficient funds in the Drug Trust Fund to pay all benefits in 1992 and assumes no payments for calendar year 1993 drug benefits.

III. DISTRIBUTIONAL EFFECT OF THE SUPPLEMENTAL PREMIUM

Based on current estimates of supplemental premium receipts, Tables 3 and 4 present distributions of the supplemental premium paid by Medicare enrollees. Tables 5 and 6 present distributions, by income, of the amount of supplemental premium at the average tax liability paid by Medicare enrollees.

Table 3 presents a distribution of the amount of supplemental premium paid per enrollee. It is estimated, for calendar year 1989, that 58.8 percent of Medicare enrollees will pay no supplemental premium and that 5.6 percent of enrollees will pay the maximum premium of $800. These figures compare to the estimates made upon enactment of 64.4 percent and 5.1 percent, respectively.

Table 4 presents the corresponding distribution for calendar year 1993. It is estimated that 52.4 percent of Medicare enrollees will pay no supplemental premium and that 10.3 percent of enrollees will pay the maximum premium of $1050 in 1993. These figures compare to the estimates made upon enactment of 57.5 percent and 9.8 percent, respectively.

The distribution of the amount of supplemental premium paid at the average tax liability across income groups, by filing status, in 1989 is displayed in Table 5.[6] For jointreturns, no supplemental premium is due, on average, below the $20,000 to $25,000 income class, and below the $15,000 to $20,000 income class for non-joint returns. The maximum premium is not reached, on average, until the $80,000 to $85,000 income class for joint returns, and the $40,000 to $45,000 class for non-joint returns.

The corresponding figures for 1993 are presented in Table 6. As is true in 1989, no supplemental premium is due, on average, below the $20,000 to $25,000 income class, and below the $15,000 to $20,000 income class for non-joint returns. The maximum premium is not reached, on average, until the $65,000 to $70,000 income class for joint returns, and, again, the $40,000 to $45,000 class for non-joint returns.

TABLE 3.—MEDICARE CATASTROPHIC COVERAGE ACT OF 1988 DISTRIBUTION OF MEDICARE ENROLLEES BY LEVEL OF SUPPLEMENTAL PREMIUM

[Calendar Year 1989]

Supplemental Premium Per Enrollee	Medicare Enrollees (Thousands)	Percent Distribution
Not Subject To Premium	19,248	58.8
Less than $100	4,031	12.3
100 to 199	2,824	8.6
200 to 299	2,024	6.2
300 to 399	1,093	3.3
400 to 499	626	1.9
500 to 599	335	1.0
600 to 699	460	1.4
700 to 799	261	0.8
Maximum Premium ($800)	1,848	5.6
Totals	32,750	100.0

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[6] The income measure used, solely for presenting distributional analysis, is defined more broadly than adjusted gross income, and does not affect, in any way, the amount of tax liability and supplemental premium paid by a particular taxpayer.

TABLE 4.—MEDICARE CATASTROPHIC COVERAGE ACT OF 1988 DISTRIBUTION OF MEDICARE ENROLLEES BY LEVEL OF SUPPLEMENTAL PREMIUM

[Calendar Year 1993]

Supplemental Premium Per Enrollee	Medicare Enrollees (Thousands)	Percent Distribution
Not Subject To Premium	18,387	52.4
Less than $100	2,302	6.6
100 to 199	2,555	7.3
200 to 299	1,599	4.6
300 to 399	1,648	4.7
400 to 499	1,270	3.6
500 to 599	1,187	3.4
600 to 699	914	2.6
700 to 799	744	2.1
800 to 899	473	1.4
900 to 999	240	0.7
1,000 to 1,049	145	0.4
Maximum Premium ($1,050)	3,612	10.3
TOTALS	35,076	100.0

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TABLE 5.—MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

[Calendar Year 1989]

Joint Returns				Non-Joint Returns			
Income class (Thousands of dollars)	Average income per return [1]	Average tax liability per return	Supplemental premium per enrollee [2] (per month)	Income class (Thousands of dollars)	Average income per return [1]	Average tax liability per return	Supplemental premium per enrollee [2] (per month)
$0-$5	$2,597	$0	$0.00	$0-5	$3,071	$0	$0.00
5-10	7,701	−14	0.00	5-10	7,056	−1	0.00
10-15	12,556	−27	0.00	10-15	12,376	105	0.00
15-20	17,514	13	0.00	15-20	17,196	576	7.20
20-25	22,516	396	2.48	20-25	22,219	1,410	17.63
25-30	27,545	930	5.81	25-30	27,274	2,035	25.44
30-35	32,378	1,559	9.74	30-35	32,333	2,902	36.28
35-40	37,599	2,281	14.26	35-40	37,254	4,773	59.66
40-45	42,374	3,057	19.11	40-45	42,840	6,396	66.67
45-50	47,516	4,147	25.92	45-50	47,076	7,637	66.67
50-55	52,052	4,991	31.19	50-75	58,098	9,486	66.67
55-60	57,527	6,683	41.77	75-100	87,280	17,041	66.67
60-65	62,609	8,204	51.28	100-200	138,035	30,268	66.67
65-70	67,491	9,848	61.55	200 and up	666,848	137,122	66.67
70-75	72,097	10,166	63.53				
75-80	77,757	10,239	63.99				
80-85	82,424	12,258	66.67				
85-100	90,057	14,942	66.67				
100-200	136,677	25,315	66.67				
200 and up	643,630	139,278	66.67				

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[1] Income is defined, solely for purposes of presenting distributional information, as adjusted gross income (AGI) plus untaxed income from: (1) untaxed social security benefits; (2) tax-exempt interest; (3) employer contributions for health plans and life insurance; (4) inside build-up on life insurance; (5) workers' compensation; (6) contributions to IRA and Keogh accounts; (7) minimum tax preferences; and (8) portion of passive losses in excess of minimum tax preferences to the extent the losses are allowed in the computations of AGI.

[2] Computed at average tax liability per return in income class.

TABLE 6.—MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

[Calendar Year 1993]

Joint returns				Non-Joint returns			
Income class (Thousands of dollars)	Average income per return [1]	Average tax liability per return	Supplemental premium per enrollee [2]	Income class (Thousands of dollars)	Average income per return [1]	Average tax liability per return	Supplemental premium per enrollee [2]
$0-$5	$2,357	$-9	$0.00	$0-$5	$2,885	$0	$0.00
5-10	7,930	-12	0.00	5-10	7,548	-1	0.00
10-15	12,771	-32	0.00	10-15	12,156	39	0.00
15-20	17,417	-21	0.00	15-20	17,333	376	8.77
20-25	22,449	240	2.80	20-25	22,380	1,020	23.80
25-30	27,458	554	6.46	25-30	27,412	1,649	38.48
30-35	32,520	911	10.63	30-35	32,373	2,295	53.55
35-40	37,453	1,592	18.57	35-40	37,257	3,604	84.09
40-45	42,376	2,319	27.06	40-45	42,631	4,856	87.50
45-50	47,445	3,099	36.16	45-50	47,400	6,670	87.50
50-55	52,384	4,068	47.46	50-75	60,698	9,044	87.50
55-60	57,230	4,958	57.84	75-100	87,293	14,592	87.50
60-65	62,383	6,530	76.18	100-200	130,153	28,074	87.50
65-70	67,341	7,607	87.50	200 and up	534,697	113,030	87.50
70-75	72,377	8,596	87.50				
75-80	78,037	9,598	87.50				
80-85	83,161	10,791	87.50				
85-100	91,755	13,676	87.50				
100-200	137,632	23,372	87.50				
200 and up	623,120	136,694	87.50				

Joint Committee on Taxation

[1] Income is defined, solely for purposes of presenting distributional information, as adjusted gross income (AGI) plus untaxed income from: (1) untaxed social security benefits; (2) tax-exempt interest; (3) employer contributions for health plans and life insurance; (4) inside build-up on life insurance; (5) workers' compensation; (6) contributions to IRA and Keogh accounts; (7) minimum tax preferences: and (8) portion of passive losses in excess of minimum tax preferences to the extent the losses are allowed in the computations of AGI.

[2] Computed at average tax liability per return in income class.

IV. DESCRIPTION OF POSSIBLE PREMIUM OPTIONS

In light of the revision of the budget estimate relating to the Medicare catastrophic program, various options for changes to that program have been proposed.

A. RETAIN PRESENT LAW

Many argue that it would be inappropriate to make significant modifications in the catastrophic program because the Act only became effective in 1989. In fact, certain benefits are not yet in effect under the program. Therefore, these individuals argue that there has not been sufficient experience in order to evaluate accurately the costs related to the program. Given the Uncertainty associated with estimating the cost of future medical benefits, these individuals argue that it is inappropriate to reduce any available funds that might be needed in the future. In addition, any reserves in the program accumulated in early years may be used to limit the increase in future Premium rates.

B. REDUCE THE MONTHLY OR SUPPLEMENTAL PREMIUM

In general

Some individuals argue that the premium for catastrophic coverage should be reduced because more revenue is projected than is needed to fund the benefits provided under the program. If this approach were adopted, the monthly or supplemental premium, or both, could be reduced.

Several options are available to reduce the supplemental premium.[7] The options for such a reduction include: (1) reducing the maximum amount of premium that an individual may be charged; (2) reducing the premium rate that is applied to each $150 of income tax liability, and (3) increasing the minimum amount of income tax liability before which any supplemental premium is due. In addition, a combination of one or more of the these options might be adopted. Any reduction could be made solely with respect to premiums paid for 1989 or for future years as well.

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[7] This discussion assumes that, in general, the present structure for calculating the supplemental premium is retained.

Reduce cap on maximum supplemental premium

The maximum amount of supplemental premium ($800 for 1989) for an individual could be reduced. Adoption of this approach would benefit only those individuals who otherwise would pay more than the revised maximum supplemental premium. In general, these individuals are those with higher incomes.

Reduce the premium rate

Under present law, the supplemental premium for 1989 is $22.50 for each $150 in income tax liability (i.e., a 15-percent tax on income tax liability) The premium rate is increased for future years. The percentage rate of the supplemental premium could be reduced. Adoption of this approach generally spreads the savings that is achieved through the premium reduction to persons in all income classes. Except for those at the maximum premium level, the effect of this option is to reduce the amount of premium proportionally to the amount that is paid under present law.

Increase the tax liability threshold

Under present law, in order to be liable for the supplemental premium, individuals must have at least $150 in income tax liability. However, eligible individuals are covered without regard to whether or not they meet this $150 threshold. Under this option, the threshold could be raised so that more low-income individuals would not be liable for the supplemental premium. Further, the calculation of the premium could be changed so that only tax liability in excess of the threshold would be subject to the supplemental premium.

If there were no change in the method by which the premium is calculated (i.e., each $150 of tax liability for those with tax liability in excess of the threshold continues to be subject to the premium), then the savings from an increased threshold would be realized by those who would be below the new threshold. If the calculation were changed so that the premium applies only to the tax liability in excess of the threshold (e.g., income tax liability above the new threshold is subject to the premium), then an increase in the threshold would reduce supplemental premium payments by equal dollar amounts to all individuals paying the premium except for those below the threshold and those who are currently at the maximum premium level.

C. REPEAL THE SUPPLEMENTAL PREMIUM

One proposal would repeal the supplemental premium and replace it with some other financing mechanism, such as a broad-based tax. Proponents of this view argue that it is unfair for high-income beneficiaries to subsidize those beneficiaries with low incomes. They contend that if a subsidy for lower-income beneficiaries of the catastrophic program is to be provided, then it should be financed by all taxpayers, not just by those individuals with higher incomes who are eligible for catastrophic benefits.

Those who support the supplemental premium argue that the premium is an appropriate method for funding the catastrophic coverage because only the potential beneficiaries of the program are required to pay for catastrophic coverage. Overall, every individual enrolled in Medicare will continue to receive a subsidy from general revenues and payroll taxes. Individuals who support this view argue that the income-related supplemental premium provides for an equitable distribution of the cost of the program.

D. REPEAL THE MEDICARE CATASTROPHIC PROGRAM

One option that has been proposed is to repeal both the coverage provided under the Medicare catastrophic program and the funding mechanism that was contained in the Act. Some argue that the costs imposed by the monthly and supplemental premiums exceed, for certain individuals, any possible benefit they may receive from the Medicare catastrophic and drug coverage. They argue, therefore, that the program should be repealed.

Other individuals point out that many of those covered receive substantial benefits under the Act and that all individuals eligible for Medicare will, on average, receive a benefit package that is subsidized by general revenues and payroll taxes. They argue that all individuals receive Medicare benefits in excess of what they pay in premiums, and that good social policy requires that such individuals be protected from the financial hazards of large medical expenses.

APPENDIX: METHOD FOR DERIVING DISTRIBUTIONAL TABLES

The staff of the Joint Committee on Taxation prepared the distributional tables on the amount of supplemental premium paid by Medicare enrollees. The distributions are prepared with the use of the individual tax model that is used for calculating changes in tax liability associated with proposed changes in the Federal individual income tax. The individual tax returns collected by the Internal Revenue Service (IRS). To supplement the IRS data, demographic and economic information is included from a variety of sources including the Bureau of the Census and the Social Security Administration. The model is weighted to reflect the total projected population of potential taxpayers and is modified to be consistent with the most recent Congressional Budget Office economic forecasts.

Tax liability, as well as the supplemental premium, is calculated for each tax filing unit in the model. For each year analyzed, the calculation of tax liability and supplemental premium is performed using the relevant rates, brackets, and definition of taxable income, consistent with prevailing law for that year.

Tables 5 and 6 present estimates of the average supplemental premium per enrollee, per month. The estimates are based on the average tax liability within an income category using the definition of income normally employed for distributional analyses.

The income concept used is broader than adjusted gross income and is designed to more accurately reflect the flow of economic income available to the taxpayer. It is defined as adjusted gross income (AGI) plus untaxed income from: (1) untaxed social security benefits; (2) tax-exempt interest; (3) employer contributions for health plans and life insurance; (4) inside build-up on life insurance; (5) workers' compensation; (6) contributions to IRA and Keogh accounts; (7) minimum tax preferences; and (8) the portion of passive losses in excess of minimum tax preferences to the extent the losses are allowed in the computation of AGI. Of course, the calculation of tax liability, and therefore the supplemental premium, is based on taxable income, and is in no way dependent on the measure of income used as the classifier for distributional presentation.

PREPARED STATEMENT OF SENATOR DAVID PRYOR

Mr. Chairman, I commend you for calling this hearing today to assess how much of the funds collected from the new Medicare catastrophic health care premiums will exceed the costs of the programs, and to evaluate options for returning any such money to its rightful owners—the beneficiaries.

Before we move onto this important subject, however, I believe it is important to take a moment to pay our respects to the man who, more than anyone else, was the standard bearer for the population of Americans the Medicare Catastrophic Coverage Act was designed and passed to assist—Senator Claude Pepper. Although he will no longer grace us with his physical presence, his spirit and his commitment to the needy will serve as a motivating force in the Congress forever.

President Bush has already stated that he believes this money should not be returned to the elderly taxpayer. He believes the Government should keep this money because the new Medicare prescription drug program is underfunded, and the money is needed to fully finance this important program.

For myself, I must question whether the catastrophic drug trust fund is insolvent. The answer to this question is vital to each and every Member of this Committee. Because if you think many of the elderly are upset now about paying a surtax to fund expanded Medicare benefits, you can only imagine how angry they will be to pay their hard-earned dollars into a bottomless account called "Deficit Reduction."

I say this, Mr. Chairman, because I believe we must be alert to the possibility that some might use the spectre of an insolvent Medicare drug benefit as a smokescreen to divert excess supplemental premium revenues for deficit reduction. I, for one, could not accept that.

If we determine that the excess surtax revenues are needed to pay for the true cost of catastrophic protection for the elderly, so be it. If not, however, that money belongs to elderly taxpayers and should be returned to them.

Congress was aware of the Administration's views about the cost of the drug benefit when we enacted this law. Because the Congressional Budget Office's cost estimate of the drug benefit was much lower, we requested a report to Congress which was to clear up the matter. However, that report, delivered on May 9, has only muddied the waters. It appears, for example, that the report contradicts the findings of the researchers who were assigned to study the question of costs and financing. I have some questions to ask Secretary Sullivan on this point later this morning.

On the question of costs, Mr. Chairman, I would like to submit some new information for the Committee's consideration that may allow us to save hundreds of millions of dollars while improving the quality of health care for the elderly. By reducing the incidence of inappropriate or excessive drug prescribing, the drug utilization review (DUR) provision included in the Medicare Catastrophic Coverage Act can accomplish this laudable goal. However, a General Accounting Office report that I am releasing today concludes that HCFA is not taking advantage of the wide range of existing quality assurance systems in its draft drug benefit implementation proposal. I will also be asking the Secretary some questions about how HCFA is going about its duties in this regard.

At this time I would like to raise another important issue that has surfaced due to the implementation of changes in the Medicare skilled nursing facility benefit under the Medicare Catastrophic Coverage Act. Effective January 1, 1989, Medicare began paying for up to fifty additional days of skilled nursing care rendered in nursing homes, eliminated the prior hospitalization requirement, and significantly reduced beneficiary cost-sharing liability. These measures have enabled more residents to benefit from the SNF coverage and for a longer period of time.

What was not anticipated, however, was that many facility residents would be abruptly transferred to another part of the nursing home for the sole purpose of assuring Medicare reimbursement when the facility limits its Medicare coverage to a limited number of its beds.

As a result, these residents have been subjected to unnecessary intrafacility transfers that have not only been extremely traumatic, but—in at least two cases that I'm aware of—resulted in the residents' death.

In some parts of the United States, there are an extremely limited number of beds certified for skilled care. As a result of the implementation of the new law, some residents in these areas are being transferred to another city to receive skilled care, far from family and friends. I do not believe that we intended to disrupt the living arrangements of nursing home residents when we passed this legislation. On the contrary, the act was to enhance Medicare coverage for those who are in the unenviable position of needing these benefits. It is important to note that Medicare eligible nursing home residents are often the sickest residents requiring skilled care on a daily basis.

Another unintended consequence of the Medicare SNF benefit improvements relates to the different requirements under Medicare and Medicaid regarding the "bed-hold" policy. Some Medicaid residents who now qualify for Medicare's skilled care benefits and require short-term hospitalization, are learning much to their surprise—that upon discharge, their bed (which in many cases has literally been "their" bed for years), is no longer available. For these individuals, their Medicare benefits have become a burden.

I believe that these important issues merit serious attention. In fact, I am considering addressing these two matters legislatively.

I congratulate the Chairman for taking this opportunity to hear from a wide spectrum of witnesses on what I expect will be a broad array of key issues. I look forward to a productive hearing.

U.S. GENERAL ACCOUNTING OFFICE, REPORT TO THE CHAIRMAN, SPECIAL COMMITTEE ON AGING, U.S. SENATE

PRESCRIPTION DRUGS—INFORMATION ON SELECTED DRUG UTILIZATION REVIEW SYSTEMS

Hon. DAVID PRYOR,
Chairman, Special Committee on Aging,
U.S. Senate

Dear Mr. CHAIRMAN: Your letter of October 26, 1988, requested that we review the implementation plans proposed by the Health Care Financing Administration (HCFA) for the drug utilization review (DUR) system required to be established under the Medicare Catastrophic Coverage Act of 1988. In the course of performing this work, we have reviewed several existing computerized DUR systems, both private and public.

Your May 1, 1989, letter indicated that the Senate Special Committee on Aging is evaluating proposals to amend title XVIII of the Social Security Act to improve the DUR system to be established under the Medicare Catastrophic Coverage Act of 1988. (See appendix 1.) You stated that the descriptive information we have compiled on the extent to which various DUR systems possess key attributes-a specified in the Special Committee on Aging report and the conference report on Medicare's prescription drug coverage and in our discussions with your staff-would be especially useful.[1]

As we understand it, the Committee needs information on the extent to which the DUR systems can identify adverse reactions that may result from:

- the interaction of the prescribed drug with one or several other drugs being used by the beneficiary,
- the interaction of the prescribed drug with a known allergy present in the beneficiary,
- the interaction of the prescribed drug with a known physical condition or illness present in the beneficiary,
- the interaction of a prescribed drug with over-the-counter drugs,
- incorrect dosages, and
- under- and over-utilization of the prescribed drug.

The types of drug and patient data the Committee is interested in include:

- the drug name,
- dosages,
- quantities,
- methods of administration,
- last date dispensed,
- identity and location of the prescribing physician or dentist,
- identity and location of the dispensing pharmacy, and
- information on diagnosis/condition.

This report presents information on the DUR systems we have reviewed and on how they compare to the provisions specified by the Committee.[2] It is important to state clearly that these DUR systems are in no way representative of the full universe of available DUR systems, nor are we endorsing them as the best systems; rather, they are the systems that we became aware of during the course of our ongoing work for the Committee. The systems we reviewed were those at Giant Pharmacies, Long Pharmacies, Thrift Pharmacies, Walgreen Pharmacies, National Data Corporation (NDC) Clinical Screening Program, Home Shopping Network (HSN) a mail-order pharmacy-and the Tri-Service Micro Pharmacy System of the Department of Defense (DOD).[3]

We examined these DUR systems by reviewing the available literature and documentation on them, observing their operations in site visits to pharmacies, and discussing these systems with experts. The following paragraphs describe the extent to which those systems present the attributes you are interested in, as well as the extent to which these attributes are identified in the conference report as being under the current Medicare authority for point-of-sale (POS) DUR screening. (See appendix II for a tabular representation of the key attributes of the DUR systems.)

ADVERSE INTERACTIONS

Looking first at the issue of identification of drug interactions, we found Adverse Interactions that all seven systems provide information on drug-to-drug interactions.

The DUR systems differ with respect to other specific types of interaction effects they examine. For example, not all the DUR systems examine the duplication of drugs (at the ingredient level) or therapeutic overlap. All seven systems examine drug-to-allergy interactions. Six of the seven systems have the capability to examine the interaction of prescription drugs to over-the-counter (OTC) drugs and the interaction of drugs and disease conditions. To make use of the drug-disease function, the private systems are dependent either on the physician to provide the diagnostic information/code or on the patient to provide this information by filling out the patient profile. Five of the seven systems have the capability to identify for interactions of drugs to food. Three of the seven systems included information on minimum and maximum dose range in their drug interaction programs. With one exception, the DUR systems we observed in operation contained no age-specific information on the elderly (for example, what the appropriate dose for the prescribed drug should be for a seventy-year-old beneficiary). Representatives of NDC indicated that their DUR system had some age-specific information on the elderly population but would not demonstrate the extent to which this information was used, citing the proprietary nature of the system.

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[1] See Special Committee on Aging, U.S. Senate, *Medicare's New Prescription Drug Coverage: A Major Step Forward, But Big Problems Still Exist,* 100th Cong., 2nd sess. (Washington, D.C.: U.S. Government Printing Office, October 1988); and U.S. Congress, House of Representatives, *Medicare Catastrophic Coverage Act of 1988: Conference Report,* 100th Cong., 2nd sess., Report No. 100-661 (Washington, D.C.: U.S. Government Printing 0ffice, 1988).

[2] See Glossary for definitions of terms.

[3] In addition, we also examined PCS, Inc., which is currently in the process of developing a prospective DUR system, Health Information Designs, Inc., and First Data Bank. Since PCS, Health Information Designs, and First Data B do not have fully operational DUR systems at present, we have not included them in our review.

All systems provided an alert for severe drug interactions—that is, instances in which the health and safety of the patient may be in danger. The mechanism and coding scheme for these alerts differed across systems, but most systems used a rating scale, with a "1" being an alert for the most serious-that is, potentially life-threatening-interaction effect.

TYPE OF DATA ENTERED

All the DUR systems we reviewed provide all the drug and patient-related information specified by the Committee, except the capability to enter data on diagnosis/condition. All systems contained information on drug name, dosages, quantities, method of administration, last date the drug was dispensed, name and/or identifier for the dispensing pharmacy, and the name of the prescribing physician. All but two systems possess the capability for entering the diagnosis or condition that prompted the physician to write the prescription.

DATA SECURITY

The issue of data security was addressed to varying degrees by the systems. Each attempted to provide some safeguards against improper access and disclosure of its patient data. The Department of Defense (DOD) system has four different levels of safeguards to protect against unauthorized access to the data base. The major safeguards of the DOD system include (1) allowing only authorized personnel to access the pharmacy function, (2) restricting user access to oniy those pharmacy functional components the user is authorized to perform, (3) restricting terminals to specific authorized functional components, and (4) providing an information trail for tracking unauthorized attempts to access the system. (At a minimum, this information trail identifies the user ID, password, terminal ID, and system date/time of each attempted access.)

SYSTEM NETWORKS

One way that all the existing systems are different from any proposed for HCFA's DUR system is the extent to which they are network systems rather than DUR systems that are specific to individual stores. The NDC system is fairly new and is not currently being used. The systems currently in use at Giant and Long Pharmacies contain only information on patients who come to stores within that particular chain for their prescriptions. That is, there is no way to tap information on prescriptions that might have been filled at other pharmacies for those some patients. The DOD system is limited to individual pharmacies within particular hospitals, with one exception. The DOD system in San Diego links 14 out-patient pharmacies, located in different parts of the city, to the main hospital pharmacy computer-system. Most Walgreen Pharmacies are store-specific, but they do have a link up of 85 pharmacies in the Chicago area through which information can be shared. All stores (450 pharmacies) within the Thrift chain are linked to a main pharmacy system. In addition, the experts we have spoken to are unanimous that a DUR system could be incorporated into the drug claim/bill processing computer system.

SUMMARY

In summary, we found that all the attributes of a system and the patient profile information of interest to the Committee are currently available in at least some operating DUR systems. We also found that issues of data security were dealt with, to some degree, by all systems. We hope this information will be helpful to the Committee in examining potential administrative and legislative actions in this area.

As we agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days from the date of this report. At that time, we will send copies to the Secretary of Health and Human Services and other interested parties and will make copies available to others upon request. If you have any questions or would like additional information, please call me at (202) 275-1854.

This report was prepared in accordance with generally accepted audit standards under the direction of Michael J. Wargo, Director of Program Evaluation in Physical Systems Areas. Other major contributors are listed in appendix III.

Sincerely yours,

ELEANOR CHELIMSKY, *Assistant Comptroller General*

APPENDIX I.—CONGRESSIONAL REQUEST LETTER

U.S Senate, Special Committee on Aging,
Washington, DC., May 1, 1989.

Hon. CHARLES A. BOWSHER,
Comptroller General of the United States,
U.S. General Accounting Office,
Washington, DC.

Dear Mr. Bowsher: The Senate Special Committee on Aging is evaluating proposals to amend Title XVIII of the Social Security Act to improve the drug utilization review (DUR) system established by the Medicare Catastrophic Coverage Act of 1988. The DUR system is intended to protect the elderly and disabled from adverse drug reactions, and to prevent expensive and avoidable hospitalizations that often result from such adverse reactions.

Staff from your Program Evaluation and Methodology Division have performed work on the Health Care Financing Administration's (HCFA) ongoing implementation of the DUR provisions of the Medicare Catastrophic Coverage Act of 1988. It is our understanding that in the course of performing this work for the Committee, GAO reviewed several existing computerized DUR systems, both public and private. It would be most helpful to the Committee if your staff could detail the key attributes of the different DUR systems studied by GAO. It is imperative that this analysis be completed as quickly as possible, to provide timely guidance in our consideration of administrative and legislative action in this area.

Should you or your staff have any questions regarding this request, please have your staff contact David Schulke or Chris Jennings of the Committee staff at 224-5364.

Thank you for your cooperation and assistance in this important matter.

Sincerely,

DAVID PRYOR, *Chairman*

Appendix II.—Key Attributes of the DUR System

DUR system information	Pharmacy chains with DUR systems							Medicare authority for POS screening
	Long	DOD	Thrift	NDC	HSN	Walgreen	Giant	
Year implemented	1981	1981	1976	1989	1989	1981	1983	1991
Number of pharmacies with DUR	237	[1] 179	450	None	N.A.	[2] 85	95	
Extent to which adverse interactions can be identified:								
Drug-to-drug	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Duplicate drug	No	Yes	Yes	Yes	Yes	No	Yes Yes	
Therapeutic overlap	No	Yes	No	Yes	Yes	No	No	Yes
Minimum dose	No	Yes	No	Yes	Yes	No	No	Yes
Maximum dose	No	Yes	No	Yes	Yes	No	No	Yes
Drug-to-allergy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Drug-to-OTC	No	Yes	Yes	Yes	Yes	Yes	Yes	[3] N.A.
Drug-to-disease	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Drug-to-food	No	Yes	Yes	Yes	Yes	No	Yes	[3] N.A.
Severity of alert	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Elderly-specific alert	No	No	No	Yes	No	No	No	[3] N.A.
Type of data entered:								
Drug name	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Dosages	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Quantities	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Method of administration	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Last date dispensed	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Appendix II.—Key Attributes of the DUR System—Continued

DUR system information	Pharmacy chains with DUR systems							Medicare authority for POS screening
	Long	DOD	Thrift	NDC	HSN	Walgreen	Giant	
Prescriber ID	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Dispenser ID	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Diagnosis/condition	No	Yes	No	Yes	Yes	Yes	Yes	Yes

[1] The DOD system in San Diego (14 pharmacies linked to a main computer) is included as one System in this estimate of 179 pharmacies; the other 178 pharmacies are independent systems that are not linked to a main computer.

[2] Of the 1,450 Walgreen's pharmacies, only 85 currently have a DUR system-all connected to a central computer system.

[3] The Medicare Catastrophic Coverage Act of 1988 does not specify that these attributes be covered by the DUR system.

PREPARED STATEMENT OF ROBERT D. REISCHAUER

Mr. Chairman, I am pleased to have the opportunity to testify before this Committee about Congressional Budget Office (CBO) estimates of the costs of expanding coverage provided by the Medicare Catastrophic Coverage Act of 1988 (MCCA). My statement today will cover three main areas:

- CBO's February 1989 estimates of the outlays and receipts from the Medicare provisions of MCCA;
- CBO's estimates of the trust fund balances; and
- The degree of uncertainty inherent in these estimates and possible changes to them.

CBO FEBRUARY ESTIMATES

The Medicare Catastrophic Coverage Act of 1988 established two financing mechanisms—a flat premium to be paid by each Part B enrollee and an income-related premium to be paid by those eligible for Part A whose federal income tax liabilities exceed $150. In February, CBO estimated for its baseline projections that over the 1989-1993 period the flat premium would generate $13.5 billion and the income-related premium would raise $25.9 billion (see Table 1).

TABLE 1.—CBO FEBRUARY 1989 ESTIMATES OF MEDICARE CATASTROPHIC HEALTH INSURANCE

[By fiscal year, in billions of dollars]

	1989	1990	1991	1992	1993	Five-Year Total
Financing Provisions (Revenues or Receipts)						
Income-Related Premium	−0.4	−5.4	−6.1	−6.7	−7.3	−25.9
Flat Premium Receipts	−1.2	−1.8	−2.7	−3.6	−4.1	−13.5
Spending Provisions (Outlays)						
HI/SMI Catastrophic Outlays	1.3	4.1	5.8	6.7	7.6	25.5
Catastrophic Drug Benefits	0.0	0.0	0.8	1.6	2.4	4.8
Drug Administration	0.0	0.1	0.2	0.3	0.4	1.1
Net Deficit Effect	−0.3	−3.1	−2.0	−1.6	−1.0	−8.0

SOURCE: Congressional Budget Office.

NOTE: Details may not add to totals because of rounding.

Two categories of new Medicare spending will arise from the MCCA: additional outlays from expanding the existing Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) programs, and outlays arising from a new program to cover expenditures on prescription drugs that exceed a certain level. In February, CBO estimated that the added HI/SMI costs would total $25.5 billion over the 1989-

1993 period, while the cost of the drug benefits would be $4.8 billion. Estimated administrative costs for the drug benefit program are expected to add another $1.1 billion in outlays (see Table 1). We did not include these estimated administrative expenses in our February baseline projections because of the convention to limit the projections for discretionary spending to programs funded in the base year (1989). Nevertheless, these expenses must be included in any assessment of the trust fund balances in future years.

CBO's February estimates show total receipts attributable to the MCCA to be $39.4 billion over the 1989-1993 period, with outlays of $31.4 billion, including estimated administrative expenses. These amounts result in a surplus of $8.0 billion.[1] When the MCCA was enacted, the CBO/JCT estimate of the five-year cumulative difference between receipts and expenditures (including administrative expenses) was $4.2 billion, or $3.8 billion lower than CBO's $8.0 billion February estimate. The primary reason for the higher surplus estimate in February is a revised estimate of likely receipts from the income-related premiums.

TRUST FUND BALANCES

The Congress planned for a surplus of receipts over expenditures for the MCCA during the 1989-1993 period to assure the timely payment of benefits, to protect against unexpected contingencies, and to account for the uncertainty in estimates of how much the program would cost. To provide these safeguards, contingency margins were included in the financing provisions of the program.

The amount of money available to make payments in a given year for the MCCA program depends not only on that year's income, but also on the balances left over from previous years. To reflect this concept, the contingency margins for the catastrophic account and the drug trust fund are calculated by determining how large the projected end-of-year balance for a given calendar year in the trust fund is when compared with the expected spending for that same calendar year. The projected end-of-year balance then reflects the amount of money left over after all payments in a given year are made, or the amount of money that would be available to pay higher-than-projected costs or to make up for lower-than-projected receipts. Because it is important to know how much will be left over relative to anticipated spending, contingency margins are discussed in terms of percentages rather than in absolute dollars.

The Congress legislated specific goals for contingency margins at the time it developed catastrophic financing provisions. For the new HI/SMI account, it set the contingency margin at 20 percent in 1992 and in subsequent years. Obviously, the Congress wanted to ensure that sufficient funds would be available in the trust funds to pay for benefits in that year even if actual costs were as much as 20 percent higher than projected at the time the premiums were set. Because of greater uncertainty about the prescription drug costs, the margins for the drug trust fund were set at 75 percent in 1992 and 50 percent in 1993. By 1996, the goal for this margin falls to 20 percent to recognize the greater certainty that will develop as experience with the new benefit accumulates.

As Table 2 shows, CBO's February estimates generate contingency margins considerably larger than those planned when the MCCA passed. These estimates show 1993 margins of 72 percent and 77 percent, respectively, for the HI/SMI account and for the drug trust fund. Whether these margins are too large or not depends on the accuracy of our estimates of receipts and spending. Because of the considerable uncertainty inherent in these estimates, especially for the prescription drug program, the scheduled contingency margins could prove to be inadequate. Even if this is not the case and projected excess reserves occur, a mechanism exists for their eventual depletion. These margins would decline after 1993 because actual program experience will determine future flat and income-related premium rates. Premium rates could be adjusted downward sooner to eliminate the excess above the original goals for contingency margins.

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[1] Adding in the administrative expenses for drug benefits that were excluded in baseline projections implies a higher surplus—$9.1 billion.

TABLE 2.—CBO FEBRUARY 1989 ESTIMATES OF CATASTROPHIC RESERVES

[By calendar year, in billions of dollars]

	1990	1991	1992	1993
HI/SMI/Catastrophic				
End-of-Year Balance	2.5	3.3	4.6	5.7
HI/SMI Catastrophic Outlays	4.9	6.1	6.9	7.9
Estimated Contingency Margin (Percent)	51	54	67	72
Scheduled Contingency Margin (Percent)	n.a.	n.a.	20	20
Drug Trust Fund				
End-of-Year Balance [1]	0.3	1.5	2.0	2.3
Drug Outlays	0.2	1.3	2.2	3.0
Estimated Contingency Margin (Percent)	174	118	92	77
Scheduled Contingency Margin (Percent)	n.a.	n.a.	75	50

[1] Category includes estimated administrative expenses.

SOURCE: Congressional Budget Office.
NOTE: n.a. = not applicable.

UNCERTAINTY OF THE ESTIMATES

While CBO provides the Congress with point estimates of the effects of legislation on the budget, these estimates have a margin of error surrounding them. The inherent uncertainty surrounding CBO's receipts and spending estimates declines when the estimates can be based on experience drawn from similar programs and policies, when relevant data is available that is both current and accurate, and when the new program or policy is not likely to induce significant changes in behavior.

Not surprisingly, the uncertainty inherent in CBO's estimates for the different provisions of the MCCA varies considerably. For example, on the receipt side, our estimate for the flat premium should be fairly reliable because the premium is similar to the SMI premium, which is currently applied to all participants in Part B of the Medicare program. CBO's estimates of the income-related premium are a bit more uncertain, both because incomes are more volatile and because we have no experience with an income tax surcharge applied to a demographic subset of the population. On the spending side, CBO's estimates of the added HI/SMI benefits are likely to be more reliable than those for the prescription drug program. This greater reliability occurs because the bulk of the added HI/SMI costs will result from the types of services that Medicare has historically covered, while the drug coverage will move us into uncharted territory.

The differences between CBO's February baseline estimates and the Reagan Administration's budget estimates for the several broad components of the MCCA illustrate the degree of uncertainty that exists. For the 1989–1993 period, the Administration and CBO have virtually identical estimates of the receipts associated with the flat premium (see Table 3).

TABLE 3.—FIVE-YEAR ESTIMATES OF MEDICARE CATASTROPHIC COVERAGE BY CBO AND THE ADMINISTRATION

[In billions of dollars, fiscal years 1989 through 1993]

	CBO	Administration	Difference (Admin.-CBO)	Percentage Difference (Admin.-CBO)
Financing Provisions				
Income-Related Premium	−25.9	−28.3	−2.4	9.2
Flat Premium Receipts	−13.5	−13.4	0.1	−0.5
Subtotal	−39.4	−41.7	−2.3	5.9
Spending Provisions [1]				
HI/SMI Catastrophic Outlays	25.5	26.6	1.1	4.3

TABLE 3.—FIVE-YEAR ESTIMATES OF MEDICARE CATASTROPHIC COVERAGE BY CBO AND THE ADMINISTRATION—Continued

[In billions of dollars, fiscal years 1989 through 1993]

	CBO	Administration	Difference (Admin.-CBO)	Percentage Difference (Admin.-CBO)
Catastrophic Drug Outlays	5.9	8.9	3.0	51.7
Subtotal	31.4	35.5	4.1	13.2
Net Budget Effect [2]	−8.0	−6.2	1.8	−22.7

[1] This category includes estimated administrative expenses.

[2] The effect for some years after 1993 will be positive as excess reserves are reduced by holding premium rates constant.

SOURCE: Congressional Budget Office.

NOTES: Details may not add to totals because of rounding. CBO estimates from February 1989. Administration estimates included in the Reagan Budget, January 1989.

There is a $2.4 billion or 9 percent gap between the Administration's and CBO's February baseline estimates of the revenues that the income-related premium is likely to generate. This difference is not as significant as it appears. CBO and the Administration are within 1 percent of each other in their estimates of the underlying tax liabilities associated with the MCCA for the 1989–1993 period. The difference largely represents different assumptions about the timing of tax payments. Specifically, CBO and the Administration have employed different assumptions regarding the relative portions of this tax liability that will be withheld from paychecks or paid in quarterly estimated tax payments, as opposed to being paid at the time tax returns are filed. CBO assumed a smaller portion of payments would be made through withholding and quarterly estimated payments than did the Administration. The Department of the Treasury recently provided information explaining the Administration's fiscal year timing assumptions for the 1990 budget. On the basis of this information, CBO has concluded that a strong case exists for adopting these assumptions in CBO's next baseline. Except for any possible change in the current baseline estimate of liability, this new timing assumption will increase CBO's estimate of baseline supplemental premium receipts by roughly $3 billion over the 1989–1993 period, with most of the increase in receipts coming in 1990 and 1991.

In the case of the prescription drug benefit, however, CBO and the Administration differ markedly in their estimates. The Administration's estimates exceed CBO's by $3 billion over the five years, but this figure understates the true difference. Inadequate balances in the drug trust fund constrain the Administration's estimated outlay for the drug program in fiscal years 1992 and 1993. If these constraints were removed, the Administration's estimate of outlays for the prescription drug benefit would total $10 billion through 1993, or $4.1 billion above CBO's estimate for the five-year period.

Differences of this magnitude occur for two reasons: the lack of recent data on the drug expenditures of Medicare recipients, and our lack of knowledge about how beneficiaries and providers might respond to the new prescription drug benefit. Let me say a few words here about both problems.

The cost of the outpatient prescription drug benefit depends on how rapidly drug expenses are likely to rise each year and on the distribution of spending for drugs by participants (that is, how many people will spend more than $600 a year and hence will exceed the deductible for 1991). Lacking any current data, CBO developed its estimates from a variety of surveys done between 1977 and 1984. While these data were the best we could find to use in estimating the costs of the prescription drug benefit, the age and quality of this information introduces a good deal of uncertainty into the February 1989 estimates of the costs of the prescription drug provisions.

As to how beneficiaries and providers might respond to Medicare coverage of prescription drugs, we face a somewhat different problem. In general, after meeting their deductible, beneficiaries will have lower net costs for prescription drugs than they would if they had no prescription drug benefit. Normally, one would expect people to acquire more of an item when the cost is reduced. However, CBO's estimate of the expected response in terms of the volume of prescriptions is quite small. This small response is the result in part of the high deductible set in the law. It also occurs because the use of prescription drugs appears to be only weakly related to having insurance coverage for prescription drugs but is significantly related to the number of visits to physicians. Since physician visits were already fairly well insured under Medicare, Medicaid, and Medigap policies before passage of the MCCA, much of the effect of health insurance on drug spending is already incorporated in the baseline spending estimates. Therefore, CBO does not expect the volume of prescriptions to increase significantly.

It is also difficult to predict how drug companies and health care providers will respond to Medicare's prescription drug coverage. Drug companies may attempt to stimulate demand for drugs by advertising to Medicare enrollees. In addition, they may be more willing to develop new drugs that they previously would have considered too expensive to market. Furthermore, physicians may be less price conscious when they prescribe drugs for beneficiaries who have met the deductible. These responses could lead to higher than anticipated drug costs. CBO's estimates do not include any adjustments for these intangible factors.

The analysis of new data should soon reduce somewhat the uncertainty of our estimates of the actual cost of the drug program. The Administration has recently issued its report to the Congress entitled, "Expenses Incurred by Medicare Beneficiaries for Prescription Drugs." In this report, the Administration provides an updated estimate of the expected costs of providing prescription drug coverage. This recent estimate is only marginally below previous Administration estimates.

On May 9th, CBO received the prescription drug data from the 1987 National Medical Expenditures Survey (NMES), conducted by the National Center for Health Services Research and Health Care Technology Assessment. In accordance with Public Law 100-360, we will report to the Congress in early July on how these new data will affect our estimates of the costs of providing Medicare recipients with prescription drug coverage.

While we have not completed our analysis, initial tabulations of the NMES data indicate that we will be revising our estimates upward. At the moment, we expect to increase our five-year estimate by $0.5 billion to $1.5 billion. This revision will narrow somewhat the difference between the CBO and the Administration's estimates, and offset some of the expected increase in projected receipts. The net effect of the two largest potential CBO revisions—the timing of income-related receipts and the costs of prescription drug coverage—would be to increase the $8 billion surplus estimated in February to around $10 billion.

CONCLUSION

I have focused my remarks thus far on the 1989-1993 period. If our estimates prove to be correct, the projected surpluses will generate contingency margins above targeted levels for the first few years. In the out-years, CBO expects the surpluses and the differences between the CBO and the Administration estimates to decline. First, our ability to estimate future receipts and spending will improve with program experience. Second, mechanisms in the law are designed to adjust future premiums to assure that adequate, but not excessive, funds are available. Third, there will be more agreement over the prescription drug costs because the number of beneficiaries will, by law, be fixed at 16.8 percent of enrollees.

Prepared Statement of Senator William V. Roth, Jr.

Mr. Chairman, I commend you for holding this hearing. I share your concerns with the need for providing catastrophic coverage to limit annual out-of-pocket expenses for senior citizens. I have great sympathy for the plight of seniors who are faced with catastrophic health care expenses and high prescription drug costs. However, as you know, we do not agree on HOW to provide catastrophic insurance to Medicare beneficiaries.

As you know, Mr. Chairman, I voted against Senate passage of the Medicare Catastrophic Coverage Act. As I said at the time the Senate voted for passage of the Medicare changes, my vote against was one of the most difficult I had ever cast. However, at that time I had strong reservations regarding the new Medicare provisions. Today, I continue to hold these reservations. In my view, the new Medicare package duplicates what many retirement plans already provided to annuitants. Presently, at this hearing, we will hear testimony suggesting changes to the Medicare program. I see the time has come for change, which is why I recently introduced legislation to alter the Medicare course.

My proposal, S. 1038 repeals all new Medicare benefits and new premiums due after December 31, 1989. The sections to be repealed include the Medicare Part B benefits, as well as the annual supplemental premium. Medicare beneficiaries will continue to enjoy the additional benefits already in effect this year such as the extended hospital coverage, 150 days of skilled nursing home care, unlimited hospice care, and the spousal impoverishment protection. Seniors will continue to pay the Catastrophic monthly premium which is currently $4.00 to cover these additional benefits (this monthly premium will be $4.90 in 1990, $5.46 in 1991, and $6.75 in 1993). But Seniors will not be charged with paying the current supplemental premium.

My proposal will not threaten the fiscal viability of the Medicare program. Congressional Budget Office estimates indicate that the flat monthly Catastrophic premium will cover the cost of the expanded acute care benefits in later years. While ensuring a continuity to Medicare beneficiaries by maintaining the current level of benefits, this legislation will also allow Congress the opportunity to develop an alternative for providing catastrophic protection to Medicare beneficiaries under Part B of Medicare.

Following passage of the Catastrophic Act as news of its provisions spread home, the more the senior citizens in Delaware learned, the less the law appealed to them. While arguments against the Medicare Act have varied, the consensus is that it raises premiums for Medicare beneficiaries, many of whom do not need this benefit. When I held a series of educational seminars in Delaware in order to help Medicare beneficiaries answer questions on Medicare, Seniors disapproval of the Catastrophic Insurance law became very clear, as the vast majority of the audience did not come to learn about the Medicare provisions but to protest the law. Reporting on these seminars, the Wilmington News Journal wrote that:

> Any Member of Congress who thought that he did the American people a favor by last year's vote for the Medicare Catastrophic Coverage Act should have been in Milford or Wilmington when well over 1,000 people came to question and protest the new law.

I am offering an alternative to the action Congress took last year. In my view, a repeal of all the Medicare Part B benefits and the supplemental premium will allow members of Congress to develop a plan that will reflect more closely the needs of Senior Americans. My proposal will allow time to study both the impact the current benefits have on Medicare enrollees and how the private sector insurance plans offered to Medicare beneficiaries are affected. While I do share the desire to protect our seniors from the devastating effect of catastrophic health care expenses, I do not believe the current Medicare package answers the needs of Seniors. In my view, these Medicare changes must be revisited.

I understand that an area that will be addressed in this hearing is the funding of the Catastrophic Insurance provisions. As the Chairman knows, I was concerned with the financial soundness of the Medicare program when the Senate considered Catastrophic Insurance, and I offered an amendment to establish a Catastrophic Insurance Trust Fund. I offered this amendment because I saw a need for clear fiscal accountability of the new Medicare Catastrophic benefits and premiums. If this program continues, fiscal accountability and viability is still of paramount importance.

I thank the Chairman for bringing this issue before the Committee. I look forward to today's testimony, and the opportunity to address the concerns of Medicare beneficiaries.

PREPARED STATEMENT OF LAWRENCE T. SMEDLEY

Mr. Chairman and members of the Committee, we appreciate the opportunity to testify this morning on the Catastrophic Health Insurance program. The National Council of Senior Citizens (NCSC) was actively involved in the development of this legislation, particularly with respect to the addition of prescription drugs as a part of the benefits package.

Catastrophic Health Insurance (CHI) can best be described as a well-intentioned effort to expand the Medicare program crafted in a conservative fiscal and economic climate. The result was a bill which does provide some significant benefit expansions without increasing the federal deficit and placing the entire financing burden of the program on Medicare beneficiaries themselves.

It is this break in the traditional approach to financing Medicare that has resulted in a national clamor among older people to make changes in the financing of the program. Had the Catastrophic program been financed through a more broadly based approach, there is no doubt that the program would have been better received.

I would like to note here, for the record, that NCSC opposed the Supplemental Premium as a financing mechanism for the Catastrophic Health Insurance program from the beginning.

In testimony as far back as April of 1987, NCSC noted that Medicare has been a financial boom to the medical industry and that reductions in reimbursements to providers should be used to pay for some part of the Medicare expansion. Specifically, we proposed that Congress should consider the possibility of rebasing the DRG categories to factor in more current cost and efficiency data and use the resulting savings, which CBO estimated at the time to be $4.4 billion, as one way of easing the financing burden of the CHI program.

Nevertheless, NCSC remains committed to the implementation of the program and the preservation of the benefits included in the final package adopted by Congress. We do, however, continue to oppose the Supplemental Premium financing mechanism for the program and believe that alternative revenues must be found as a substitute for the Supplemental Premium.

I want to make clear that we are not suggesting now, nor have we ever suggested, that the beneficiaries should be absolved from paying some part of the new Medicare expansion. Even if the Supplemental Premium were eliminated with funds derived from newly raised general revenues, beneficiaries would still be responsible for financing over one-third of the program through increases in the basic Part B premium.

Let me say at the outset that we commend you, Mr. Chairman, for your willingness to hold this hearing and your recognition that the Catastrophic program should not be used as a tool for deficit reduction. If, as it now appears, there are surplus revenues above the estimates necessary to finance the Program's benefits, we believe that this surplus should be returned to beneficiaries in an expeditious and equitable manner.

With respect to the surplus, we believe that some combination of across-the-board rate reductions and an increase in the threshold for paying the Supplemental Premium should be considered by this Committee. We do not support a reduction of the cap on maximum payments (currently $800 for an individual and $1,600 for a couple) to be an appropriate way of returning excess revenues to beneficiaries. Clearly, a reduction in the cap would provide relief only to those Medicare beneficiaries with the highest annual incomes and offer no relief to middle-income elderly taxpayers.

Beyond the question of excess funds and how they should be distributed, NCSC continues to oppose the Supplemental Premium mechanism as a basis for financing the Catastrophic Health Insurance program. We believe that it is as unfair to ask older people to pay the entire cost of the CHI program as it is to ask parents of school-age children to pay the entire cost of public schools. Such programs are responsibilities of society as a whole and all of society receives benefits. Thus the burden of financing these programs should be shared by all Americans.

This is not to say that all Americans should pay equally for public programs. It is the purpose of our progressive tax system to ensure that payments are made based on levels of income. As income rises, so should the taxation burden. This principle serves as the foundation of our nation's belief in economic justice. It also served as a basis for the 1986 Tax Reform Act, a fact that has direct relevance to our recommendations for corrective action on the financing of the Catastrophic Health Care program.

However, before we turn to our recommendations for changes in the CHI program, I would like to mention other objections we have to the Supplemental Premium financing mechanism:

(1) To a significant extent, most of the benefits of the CHI program are directed toward lower-income older persons who do not have and cannot afford private Medigap insurance. For those who do have such coverage, the Part A hospital cap and the Part B physicians' cap are largely duplicative. Similarly, many Medigap policies offer substantial protection against the costs of prescription drugs.

Even if this were not the case, the CHI program is not a good deal for many seniors. By 1993, when the Health Care Financing Administration (HCFA) estimates the actuarial value of the catastrophic program will be $322 per beneficiary, the maximum Supplemental Premium plus flat premium will total $1,172.40.

Therefore, the effect of the CHI program is to have the well-off elderly subsidize the lower-income and poor elderly. As we already said, NCSC strongly supports the concept of the wealthy contributing higher taxes to support the less well-off, however, we do not believe this should not be done on a generational, categorical or occupational basis.

To some extent, this subsidy was to have been mitigated by reductions in Medigap premiums as private insurers made adjustments to their policies to conform to the Medicare expansion. Not only has this not occurred, but many insurance companies, including Blue Cross/Blue Shield, have, in fact, increased their premiums. According to the Blue Cross/Blue Shield Association, the average annualized premium rate for Medicare subscribers has increased by 8.5 percent since the enactment of the Catastrophic program.

We do know that some unions have or are in the process of negotiating rebates to retirees based upon the actuarial value of the CHI program, which is estimated by the Health Care Financing Administration to be $65 per beneficiary in 1989. But even this provision, which does not reach many older persons, is due to expire as the larger benefits provisions of catastrophic are phased in.

(2) The imposition of a Supplemental Premium on elderly taxpayers is a violation of the principles established in the 1986 Tax Reform Program. As a result of the Catastrophic law, middle- and upper-income senior citizens are now required to pay a higher marginal tax rate than the rest of the population.

For these reasons, NCSC believes that the Supplemental Premium should be repealed and that revenues should be substituted that conform to the intent of the 1986 Tax Reform Act and that are paid for by the population as whole. This does not mean that we simply want to shift the burden from all elderly taxpayers to all younger taxpayers. The solution we support is far more progressive than that, and it is one that would rectify a gross inequity in our current tax system.

As you well know, Mr. Chairman, under current law, single individuals with incomes between $47,000 and $109,050 and couples with incomes between $79,000 and $208,510 pay a marginal tax rate of 33 percent. Individuals and couples with incomes above these levels see their tax rates drop back to 28 percent. This is a clear violation of the principle of progressive taxation and beyond the bounds of tax equity.

As you have already heard this morning, Senators Tom Harkin (D-Iowa) and Carl Levin (D-Mich.) along with Representative David Bonior (D-Mich.) have introduced legislation to rectify this inequity in the tax law and use the additional revenues to eliminate the Catastrophic Supplemental Premium. NCSC endorses this legislation as a way of broadening the financing responsibility for the CHI program to society as a whole but doing so in an equity manner.

The Joint Tax Committee has projected that this proposal would be virtually revenue neutral over four years and, according to CBO, would only affect some 600,000 of America's wealthiest taxpayers. We hope that your Committee will consider the Harkin/Levin plan as one way of reducing the law burden now placed on Medicare beneficiaries.

I am concerned that too many people have lost sight of the very different objectives of programs like Medicare from those that are not of social insurance design. The goal of Medicare is to protect older Americans from financial exposure due to illness or hospitalization; it is not to redistribute income or benefits from within one age group. We believe that income redistribution should be primarily carried out through progressive taxation and used to meet our nation's pressing needs. We do not disagree with those who say that the rich elderly should pay more to support our government, but they should do so because they are wealthy, not because they are elderly.

Finally, Mr. Chairman, I would like to express our organization's continuing desire to work with you and members of the Senate Finance Committee to find ways of improving the Catastrophic Health Insurance program that are fair not only to current Medicare beneficiaries, but also to all of us who one day hope to become beneficiaries. Thank you.

Prepared Statement of Louis W. Sullivan

Mr. Chairman, and Members of the Committee: Good morning. I am pleased to be here today to discuss with you financing issues related to catastrophic health insurance under Medicare.

The Administration's report recently transmitted to Congress entitled "Expenses Incurred by Medicare Beneficiaries for prescription Drugs" confirms our initial estimates of the drug benefit, and indicates that the financing of the Catastrophic Drug Insurance Trust Fund is not adequate. The drug trust fund is seriously underfunded; the basic catastrophic benefits (the catastrophic benefits exclusive of the outpatient prescription drug benefit) are appropriately funded.

BACKGROUND

Catastrophic health insurance represents the most comprehensive expansion of Medicare since the program's inception in 1965. The concept of catastrophic health insurance was forwarded by the former Administration and embraced by Congress over two years ago. Following more than a year of Congressional debate and months of dialogue between Congress, the Administration, and beneficiary groups, the Medicare Catastrophic Coverage Act of 1988 became law last July.

Catastrophic health insurance may protect Medicare beneficiaries from the financial ruin an unusually long or particularly expensive acute illness may cause. The need to protect Medicare beneficiaries from such risk has become increasingly clear in recent years as the cost of health care has risen dramatically, and with it the burden of beneficiary cost-sharing for the most serious illnesses. While I think most of us are familiar with the details of the catastrophic health insurance benefits, let me outline them briefly for the record.

CATASTRONHIC HEALTH INSURANCE BENEFITS

Part A Benefits: Under Medicare part A, beneficiary financial liability for inpatient hospital care will be reduced. Beginning January 1, 1989, beneficiaries are entitled to unlimited hospital care, following payment of only one hospital deductible per year. In addition, hospital coinsurances are eliminated.

Medicare coverage of skilled nursing facility services also is expanded under the new benefit, with Medicare now paying for 150 days of care annually with significantly reduced coinsurance amounts. And, the requirement that a beneficiary must be hospitalized for three days prior to being admitted to a SNF has been dropped.

To round out part A coverage, both the hospice and home health care benefit have been enhanced. Medicare beneficiaries choosing the hospice option are entitled to an unlimited number of hospice days effective January 1, 1989, providing a physician certifies that hospice care is appropriate. Beneficiaries requiring home health care will find the number of covered days for daily nursing care expanded beginning in January of 1990.

Part B Cap: Under catastrophic health insurance, beneficiaries will be guaranteed that their out-of-pocket costs for physician and other part B services will not exceed a reasonable amount. In 1990, for example, the cap for such covered part B services is set at $1,370. Medicare will pay 80 percent of covered part B services until a beneficiary's out-of-pocket expenses exceed $1,370. At that point, Medicare will pay 100 percent of covered part B services. This benefit protects not only those beneficiaries experiencing a sudden illness, but also will likely help those whose chronic illness requires extensive physician services.

Other Part B Benefits: Catastrophic health insurance will provide in-home respite care beginning in January 1990. This benefit allows up to 80 hours of continuous care annually for certain disabled beneficiaries, thus providing needed respite for their usual caretakers. In addition, Medicare beneficiaries will be entitled to preventive screening mammographies beginning in January 1990.

Outpatient Prescription Drugs: An entirely new benefit, Medicare coverage of outpatient prescription drugs, has also been added under catastrophic health insurance. Beginning in 1990, Medicare will pay for immunosuppressive and certain home intravenous (IV) drugs. In 1991, the benefit expands to include all other outpatient prescription drugs approved by the Food and Drug Administration (FDA). An annual deductible is generally required before Medicare payments begin. In 1991, for example, the deductible is $600. The required coinsurance will be reduced over the first several years of the program from 50 percent in 1991, to 40 percent in 1992, and 20 percent as early as 1993.

Low-Income Protections: Finally, catastrophic health insurance provides special protections for low-income beneficiaries. Under the law, States are required to pay the Medicare premiums, deductibles, and coinsurances of all beneficiaries with incomes below the federal poverty level. In addition, a new Medicaid benefit allows a spouse who remains at home to keep a minimal level of income and assets when the other spouse is admitted to a nursing home. This important provision protects an individual who wants and is able to stay in the community to do so without becoming impoverished trying to pay the nursing home bills of a spouse.

THE FINANCING DILEMMA

The benefits I have recounted were incorporated into the catastrophic health insurance legislation for several reasons. First, millions of beneficiaries lack this coverage. While most beneficiaries purchase private insurance to supplement Medicare coverage, these plans vary in the extent to which they cover acute catastrophic expenses. Some beneficiaries lack catastrophic coverage entirely; some intentionally, others for lack of resources. Thus, some beneficiaries are not adequately covered for the risk of incurring acute catastrophic expenses. In addition, as you well know, several groups representing Medicare beneficiaries encouraged the development of the legislation and were actively involved in its evolution. Finally, because the benefits are financed by beneficiaries themselves, the underlying principle of the financing mechanism for the benefits is fiscally prudent.

As Congress greatly expanded the relatively modest benefit proposal initially forwarded by the Reagan Administration, it became clear early on in the Congressional debate that flat premium financing, that is, premiums paid in equal amounts by all beneficiaries, would have been excessive for a great many beneficiaries. The financing mechanism which subsequently emerged to support the benefits included a flat part B premium to be paid by all Medicare beneficiaries, and a supplemental premium related to Federal income tax liability. Revenues from the flat part B premium finance about one-third of the catastrophic benefits while revenues from the supplemental premium finance roughly two-thirds of the benefits.

This financing mechanism represents a fundamental change in the way Medicare benefits are financed in at least two respects. Perhaps the most significant aspect of the financing mechanism is that, for the first time, new Medicare benefits are to be financed solely through premiums paid by beneficiaries themselves. The development of the legislation was contingent upon sustaining this feature: both Congress and the Administration agreed that general revenues would not be used for the further expansion of Medicare benefits. Second, beneficiaries with higher incomes are required to pay supplemental premiums in order to preserve the benefits package. It is reasonable to expect all individuals who could benefit from the new law to contribute to its cost.

The new financing mechanism had the potential to entirely derail the legislation, and, indeed, many opposed it in principle. However, when the choice became one of adopting the new benefits financed by both flat and supplemental premiums, or not securing the benefits at all, everyone—Congress, the Reagan Administration, and beneficiary groups—supported, on balance, the legislation. I would point out, however, that even as President Reagan signed the bill into law, he cautioned policy makers that the volatile costs of the outpatient prescription drug benefit could far exceed what was projected.

Some beneficiaries have taken issue with the financing mechanism designed to pay for the new benefits. I understand that many in Congress have heard from those beneficiaries who believe that the supplemental premium is unfair, both in principle and in the amounts to be paid. We at the Department hear from these beneficiaries as well, and I believe we would be recreant in our responsibility to them not to carefully examine their concerns. At this time, however, we remain committed to the continuing implementation of catastrophic health insurance under Medicare.

THE "SURPLUS"

As I understand it Mr. Chairman, your proposal for reducing the supplemental premium by an average of 16 percent is premised on revised Congressional Budget office (CBO) and Joint Committee on Taxation estimates of premium revenue. These re-estimates reveal a larger contingency margin than estimated when the legislation was enacted. I note that the contingency margins specified in the legislation may not provide adequate protection. If they were calculated using accepted actuarial methods, they would translate to a five percent margin.

You propose to use this so-called "surplus" to reduce supplemental premium amounts. Allow me to outline several reasons why we believe your approach is not in the best interests of beneficiaries or the Medicare program.

The Administration has also re-estimated the costs of catastrophic health insurance. While it is true that premium revenues are somewhat higher and benefit outlays are somewhat lower than projected when the legislation was enacted, we remain concerned that the outpatient prescription drug program is in a seriously compromised financial position. We cannot recommend a reduction in premium revenue at this time, knowing that the drug benefit faces financial difficulty in the near future.

The new estimates of the Medicare outpatient prescription drug program continue to show that the program is considerably underfunded. Over the first four years of the program (1990–1993), benefit payments are expected to exceed premiums received by nearly $800 million. With administrative costs included, the shortfall rises to almost $2.8 billion. By the end of 1992, we project that there will be insufficient cash on hand in the Catastrophic Drug Insurance Trust Fund to pay claims, and some benefit payments will have to be deferred until additional premiums come in.

I understand that HCFA actuaries and CBO have never been in agreement with regard to the cost of the outpatient prescription drug benefit. Let me describe some of the assumptions the Department used in calculating its most recent estimates.

The Department estimates that Medicare beneficiaries who purchased at least one outpatient prescription in 1988 purchased an average of 21.5 prescriptions in that year. We estimate that by 1993, outpatient prescription drug users will purchase an average of 23.3 outpatient prescriptions. We also estimate that the average cost per outpatient prescription drug in 1988 was $18.21, and will increase to $24.26 by 1993.

Perhaps the most difficult element of the program's cost to estimate is that of induced demand. It is commonly acknowledged in the insurance industry that the very act of coverage tends to increase demand for the covered service. This insurance effect is called "induced demand." HCFA actuaries assume an insurance effect in 1991 that would increase aggregate consumption of drugs by the Medicare population by about 10 percent. In 1992, as the coinsurance rate for outpatient prescription drugs falls, aggregate consumption is projected to be about 12 percent higher than it would have been in the absence of the program. In 1993, an increase in the deductible and a decrease in the coinsurance rate produce effects that partially offset each other, resulting in consumption that is projected to be about 11 percent greater than what would have been the case in the absence of the program.

Estimating future outlays is always a risky business, and, in this case, the dearth of good information on which to base estimates makes it even harder. We need to be very cautious in our financing of this new benefit—we cannot afford to contribute to the insolvency of the drug trust fund.

If history can provide any insight into the inherent difficulty of estimating the costs of new benefits, we need only look at the evolution of other benefit programs to learn valuable lessons.

- When the original Medicare legislation was enacted, part A benefit outlays were projected to be $5.7 billion for the four year period CY 1967–1970. Actual part A benefit outlays for FY 1967–1970 were $15.7 billion. We anticipate FY 1990 part A outlays of $63.1 billion.
- When the End Stage Renal Disease Program (ESRD) was implemented, it was expected to cost $710 million for a four year period 1974–1977. The program's actual costs in those years were $878 million. In FY 1990, we project comparable ESRD expenditures of $1.15 billion.

While there are many reasons, including benefit expansions, why these programs grew faster than we predicted, I think we would be wise to keep them in mind, and proceed with seasoned caution rather than youthful optimism at this point. In drafting the catastrophic coverage legislation, Congress provided for the possibility that the program could be initially overfunded. To address this possibility, the current financing structure contains a mechanism to hold the line on premium increases starting in 1994 if too much revenue is collected during the early years of the program. However, if Congress were to cut the premium rates today, there is no comparable automatic mechanism to increase premiums in time to maintain the solvency of the drug trust fund.

In addition, if premiums were reduced and the actuary's estimates confirmed by actual expenditures, Congress could be forced to introduce general revenues into the financing mix. This may at first be presented as a temporary fix but once done it would be very difficult politically to reverse. A first principle with respect to the legislation was that no general revenues should be used. And Congress, throughout discussions on this legislation, was in agreement on this point.

In light of these very sobering points, it would be extremely injudicious to reduce supplemental premium revenues before all of the catastrophic benefits are fully implemented.

IMPLEMENTATION SCHEDULE

I should point out at this time that the implementation schedule for the drug benefit is extremely tight. Implementation on January 1, 1991 will require the timely execution of a number of critical tasks both inside and outside of the Department. Perhaps the largest task we face is the procurement of the Congressionally mandated electronic bill processing system. The full cooperation of all parties will be required in order to accomplish what is, by any measure, a very complex procurement. There is virtually no tolerance in this schedule. Any delay in this process will make implementation within the legislatively required timeframe extremely difficult to achieve.

CONCLUSION

In concluding my remarks, I would point out that the Medicare program remains a Federally subsidized health insurance program. The bulk of part A benefits are paid for by current workers through a payroll tax, and 75 percent of part B benefits are financed through general revenues. Clearly, although Medicare beneficiaries have been asked to contribute to financing the new benefits, they are still paying far less than the market value of their Medicare benefits.

Let me conclude my statement by assuring you that we want to encourage discussion of issues affecting the Medicare program. We will continue to listen to beneficiaries and taxpayers, make changes where we can, hopefully make decisions characterized by integrity and prudence in the long run, and above all, do what is in the best interest of beneficiaries. Indeed, I believe that more harm can be done by being overly optimistic about the financing of these new benefits than by being prudently cautious. The continuing implementation of catastrophic health insurance under Medicare is the most appropriate course of action.

Thank you, Mr. Chairman. I would be pleased to answer any questions you may have.

RESPONSES OF SECRETARY SULLIVAN TO QUESTIONS SUBMITTED BY SENATOR BENTSEN

PRESCRIPTION DRUGS

Question 1. On page 22 of the Department's recent drug report you say: "Data from the NMES survey were not used to determine the aggregate level of consumption population surveys also reflect errors of recall and omission on the part of respondents . . . Consequently reliance upon NMES alone to establish the level of expenditure for prescription drugs would lead to underestimate of actual experience." This sounds like a pretty sweeping rejection of survey data your Department spent tens of millions of dollars collecting. Moreover, as we understand your earlier estimates made at the time of passage, they were based on similar population surveys—especially the current Medicare Survey. Aren't the recent data from retail pharmacies being used by your actuaries, in effect, a nonscientific survey of administrative records from pharmacies concentrated in particular states that happen to work with selected software vendors? If so, don't these data suffer from some biases too?

Answer. Far from rejecting the NMES, we have merely recognized that no one survey method is appropriate for all purposes. The weakness of household surveys is discussed on pages 52–54 of the report to Congress. As noted there, the Survey Research Center at the University of Michigan, one of the most prestigious survey centers in the nation, has concluded that such surveys are not appropriate instruments to establish either national aggregates or attributes with very skewed distributions.

The Current Medicare Survey (CMS) was considered more reliable in establishment of aggregates than NMES for two reasons. First, CMS was conducted monthly. This level of contact, more frequent than the quarterly contact in NMES, is likely to minimize errors of recall. It is well documented that people are likely to forget purchases as time passes, especially small purchases such as drugs. Second, the CMS was conducted over a ten-year period, which allowed time for the survey instrument to be tested and refined. The pattern of estimates produced from the CMS attests to this. After an initial period of instability, mean prescriptions per person settled down to a fairly smooth, plausible trend.

It is true that the Pharmaceutical Data Services (PDS) data set used in the Administration estimates also suffers from biases. This is true of any data set. The data are taken from pharmacies with particular software, rather than from a random sample of pharmacies. However, there is no compelling evidence that the *people* who frequent these pharmacies are not representative of *people* in general. The data are geographically skewed. However, this geographic skew can be corrected and we have done so. What is important is that the PDS data set contains information on 10 million prescriptions and some 500,000 aged beneficiaries.

In conclusion, it is incorrect to conclude from our use of the PDS data to establish the mean level of prescriptions that we have rejected NMES. The correct conclusion is that HCFA chose to make use of a number of data sources and built on the strengths of each, rather than to rely upon a single data source.

Question 2. I'm having trouble reconciling the assumptions on *induced demand* from Chapter 3 of your report with the induced demand estimates contained in Appendix 5. The HCFA actuaries assume a 10 percent to 12 percent increase in aggregate spending, which translates into about a 30 percent increase for the portion of spending exceeding the deductible. In contrast, NCHSR estimates essentially have no change in spending when looking at actual experience under Medigap plans with far more generous coverage than will be available under Medicare.

Can you straighten me out on this puzzle?

Answer. The analysis conducted by the National Center for Health Services Research and Health Care Technology Assessment (NCHSR) concerning induced demand is an econometric study. Therefore, it is important to establish first that the study cannot refute the notion of induced demand. Rather, the appropriate conclusion is that using a particular model of demand, NCHSR could not statistically verify induced demand in *the sample used*. The sample data were taken from a survey 10 years old. There was a fair amount of imputation applied to the original data. As pointed out by an NCHSR consultant, people with drug insurance may be more likely to underreport use than are people without coverage (page E-5 of the report) The model used assumed that any correlation between drug use and physician visits reflected one-way causality: that is, greater physician coverage would lead to more drug use, but greater drug coverage would not lead to more physician use.

In contrast to the NCHSR study, insurance companies with actual experience in prescription drug programs have found that use of drugs after institution of insurance exceeded expectations by a considerable amount. When preparing an analysis of the drug trust fund, in which literally billions of dollars of benefits are at risk, HCFA actuaries chose the more prudent course of relying upon actual experience rather than econometric modeling.

In summary, there is no real puzzle. NCHSR has conducted an analysis of one data set. They also looked at another data set (the MEDCO data) and found evidence of considerable induced demand. After peer review, these studies will become part of the body of literature on induced demand. HCFA depended upon that body of literature and upon insurance company experience to derive an insurance effect.

Question 3. The Congress worked hard to design some *reimbursement* limits that would save on the costs of the program, compared to current spending. We can't find information in your report showing how much you estimate to be saved by those provisions.

Please tell me something about this.

Answer. HCFA actuaries are working to simulate the effect of the reimbursement limits. This is not an easy task, since the formulae depend upon the type of drug, the type of prescription, the type of pharmacy, and the establishment of a distribution of charges and acquisition prices. Recall that pharmacy industry sources indicate that 68 percent of the cost of a prescription is made up of the average wholesale price (AWP) which is not really controlled under the law, except in the case of multiple source drugs (where half of the cases are likely to have reduced AWP and the other half increased AWP) Given the weight attached to the presently unconstrained AWP, it is unrealistic to assume that reimbursement limits will have a substantial effect upon program costs.

Our experience with the supplementary medical insurance (SMI) program shows us that providers are usually able to circumvent payment controls in an otherwise open program. As a result of this experience, HCFA actuaries prudently decided to await solid evidence from the Catastrophic Drug Insurance (CDI) program before ascribing cost savings to an untested payment system.

Finally, utilization review (UR) programs are effective only to the extent that they control unnecessary demand. To the extent that induced demand arises from legitimate drug needs, UR will not reduce costs. And, any reduction in use accomplished by these UR programs is already reflected in the prescription data provided by PDS.

Question 4. Your estimate of prescription drug outlays in Table 6 of the report does not include *administrative costs*. We are concerned about these costs and would like as many of the details as possible. For example, can you tell us about the split between central HCFA costs and the bill processing costs that vary with the volume of claims?

Answer. We cannot release exact administrative estimates at this point because we are in the process of procuring the services of the three drug bill processors. Disclosure of this information could adversely affect bids from the prospective offerors. However, for budget purposes, HCFA actuaries estimate administrative costs of about $2 billion for the first four years of the program (1990–1993).

Question 5. There are several places in the Department's report where the validity of the (NMES) data is questioned. However, in the part of the report dealing specifically with NMES, validity checks show *no* evidence of under-reporting of use and accurate reporting of charges by the Medicare population (not for the population as a whole where pediatric drug reporting may be a problem). Given their findings, why was NMES data discarded in developing aggregate per capita estimates?

If there are inaccuracies with NMES data, how do you explain the NCHSR finding that the data seem valid? Or interpret the statement on page 28 of the Department report that "the NMES estimates of cost per prescription fell squarely on the trend line."

Answer. I must emphasize again that we have not questioned the validity of all of NMES, but rather of national aggregates based upon household data in general. Let me also direct your attention to page E-13 of the report. A comparison of aggregate data between NMES and two major data sets "suggests an overall underreporting rate in NMES of approximately 20 percent." This rate does not reflect the exclusion of much insulin (often a nonprescription item) from the two industry figures, nor does it reflect the exclusion of hospital outpatient and mail service pharmacy from those data sources. Both of these effects would exacerbate the underreporting rate.

Question 6. It is usual when reporting survey data to present margins of error; even political pollsters present this information. Standard errors are reported for NMES, but no such information is provided for the estimates in Tables 3 and 4 of the Department report. Why is no such information provided?

Without these margins of error, how do we know the 20.7 prescription per elderly user reported in Table 3 is different from the 18.1 estimate of NMES?

Answer. Statisticians, "even political pollsters," use random sampling techniques to draw their samples. These techniques, combined with assumptions about the underlying distribution of the population, allow construction of standard errors.

In the case of actuarial estimates, in which statistical and non-statistical data are combined to form an answer to a problem, it is very difficult to determine standard errors. By their nature, the estimates are usually not statistical, but rather involve a high degree of personal judgment. Such is the case with any actuarial estimate, regardless of whether it is made by private insurance actuaries or public program actuaries. Nor, for that matter, is it common for the Congressional Budget Office (CBO) to prepare standard errors for their estimates of the cost of new programs. As the Administration works on the Trustees' report for the CDI program, optimistic and pessimistic scenarios will be developed to show a plausible band of experience; even these, however, cannot be linked to specific probabilities of occurrence.

Assuming that PDS data compromises a random sample of people (if not of pharmacies), the standard error of the mean is very low. This is attributable to the large number (573,000) of people involved. The number of observations also allows us to bypass use of the Chebyshev inequality and to use the central limit theorem to approximate a 95 percent confidence interval. That interval is (12.7, 12.9). Similar use of the central limit theorem generates a 95 percent confidence interval for the number of pharmacies per user of (1.46, 1.58). Assuming that the two means are independent (even if the underlying causal mechanisms are not) a 95 percent confidence interval for the 19.5 mean community pharmacy prescriptions per user is (18.7, 20.3). No comparable method of determining a range for the correction factor adjusting for the outpatient/mail service use can be constructed.

The NMES mean prescriptions per user has a standard deviation of .368 prescriptions (Table H-5 of the report). If we apply that standard deviation to the aged user mean of 18.1, we can derive a 95 percent confidence range for the NMES average prescriptions per capita of (17.4, 18.8). By comparison, the noninstitutional aged mean prescriptions per capita implicit in the actuarial estimate is 19.7, less than 9 percent higher than the NMES mean; the difference can be ascribed to underreporting in NMES.

Question 7. Administrative data are not free from error. How was the Pharmaceutical Data Service (PDS) prescription data that were used in deriving the Department estimates corrected? And what measures were used to check the validity of these data?

The Service prescription data clearly do not reflect the geographic distribution of Medicare beneficiaries. To make estimates, adjustments had to be made to correct for the problem. Similar adjustments should have been made based on age, race and gender (at a minimum). Why are there no details of the adjustment methods—geographic or demographic included in the Department's report.

Answer. Table 3 of the report to Congress summarizes the alterations made to the "published" PDS customer mean to arrive at HCFA's mean prescriptions per user. These alterations are discussed on pages 19 through 21. Please note that the starting point, 14.2 prescriptions per customer, is lower than that published elsewhere by PDS. This is attributable to the rejection of a number of customers by HCFA, using clearly incompatible age and sex values on individual records. (All of these records were traced back to one vendor, who had inadvertently combined many patient identifications into one.)

No mention is made of demographic alterations in the PDS data because we do not share your conviction that "adjustments should have been made based on age, race, and gender (at a minimum)." Our examination of the PDS data set showed a proportion of female customers that was higher than the proportion of females in the Medicare population, but NMES suggests that females use more drugs than do males, so that this observation was expected. Similarly, the PDS data set was somewhat younger than the Medicare population. This observation may be attributable to higher institutionalization rates (and more reliance upon one pharmacy) for the very old. The differences were not believed to be significant. Race was not coded on the PDS set, but NMES data (Table 5 of the report) suggest that its omission was not very important.

Question 8. The one adjustment we do know about converting Service prescription *customers* to *users* depended upon information from 1024 individuals. How do we know they are representative of all Medicare individuals?

How do we know these data were appropriate to make adjustments for individuals who are the highest users of prescription drugs and who would therefore incur prescription costs of more than $700 in 1993 and beyond?

Answer. The 1,024 people used to convert customers into users in the PDS data set showed roughly the same age and sex distribution as the general aged population, with the exception that the sample tended to over represent the "young" aged below age 80 at the expense of "old" aged above age 80. I have already discussed the possible cause of that disparity at question 7.

The adjustment is totally independent of the distribution of drug users. The purpose of the adjustment is to adjust the number of *customers* so that we can find the unduplicated number of *people* involved. This is appropriately done at an aggregate level and has no bearing upon the ultimate distribution around the mean number of prescriptions.

And, may I point out that a recent study of the Pennsylvania drug program, the PACE program, supports our adjustment. In fiscal year 1986, records for 28,949 aged were examined to determine the number of pharmacies used in a year. That group's average was 1.45, a figure quite close to our 1.52.

Question 9. Since the PDS senior prescription data only report how a prescription was paid at the point of sale, there is no information on whether individuals were reimbursed directly by third party insurance. As noted in the report, there is no information on source of payment for over 70 percent of the senior prescription sample. The discussion of Table 2 on pages 7–8 makes statements ignoring this problem with the data. Why is this information included (Table 2) since it is at best misleading?

Answer. Actually, the reported source of payment for some 70 percent of prescriptions in the PDS data for 1988 is cash, not "unknown." Upon re-reading the text on pages 7 and 8, you will see the statement, "Undoubtedly, some of the remaining 70.1 percent of prescriptions were later reimbursed by insurance carriers who did not have an assignment agreement with the dispensing pharmacist."

This material was included in the report at the direct request of the Committee Report accompanying the final Medicare Catastrophic Coverage Act legislation. Because insurance data from NMES were not yet available, we believe we used the best data we could find.

Question 10. If the Department is concerned with the validity of the NMES data, how do you explain the close match between estimates of use based on data provided by PDS and NMES

Why do you consider data collected from pharmacists to be more scientifically suitable for making national estimates than survey data? Hasn't HCFA traditionally used survey data to make estimates?

Answer. Once again, let me repeat that the Department is not concerned about the validity of NMES.

The estimates of mean use from NMES and PDS differ by about 9 percent, reflecting underreporting in NMES.

The discussion of reasons for using various data sources in different ways has been discussed in the report (see page 15, Appendix 1, and the Technical Appendix E to Appendix 5) and in answers to earlier questions.

HCFA has not traditionally used household survey data to make national estimates of spending.

Question 11. The shape of the use distribution of prescription drugs is important in making accurate cost estimates. The Department claims the gamma function describes this pattern. Why is there no evidence in the report to support the use of this statistical function?

How do the predictions of these spending in excess of $500 in 1987 using this function compare with NMES findings?

Answer. The reason no evidence is given in the report for the use of the gamma function to approximate drug spending is that a gamma distribution is a standard assumption in the field. The actuarial literature in risk theory recommends using the gamma distribution for large numbers of claims.[1] The RAND study used a negative binomial distribution[2] which approaches a gamma distribution when the number of cases is large.[3] Empirically, we found the gamma distribution closely approximated the drug spending of the half a million people in the PDS data. It was our understanding that CBO also used a gamma distribution in its estimate of drug spending.

The distribution of the NMES prescription data matches a gamma distribution with beta of .87 quite closely.

Question 12. Why do you assume the existence of "induced demand" for prescription drugs in the face of a careful study at NCHSR that demonstrates that this is not the case?

In the studies you do cite evidence for the existence of "induced demand." How did those who carried out the studies control for the impact of physician visits or adverse selection of prescription drug coverage among those with unusually high drug costs?

Answer. First, I would point out that the NCHSR study is but one of a number of studies of induced demand. Since a review of the methodologies used would be rather cumbersome, I would direct your attention to the several references listed in the bibliography of the report. In addition, Department staff would be pleased to discuss the details of various methodologies further with you.

Question 13. I would like to explore for a moment the relationship between the additional Part B premiums imposed under the new catastrophic insurance program and the current Part B premium, which currently cover 25% of program costs through the end of 1989. If this 25% requirement is extended, as proposed by the President, you will retain a great deal of flexibility about the level of reserve margin appropriate in financing the pre-catastrophic Part B benefits. In the past, what general level of reserve margin has the Part B premium been set to achieve? What would your policy be should Congress extend the 25% requirement?

Answer. Based on the past program experience, it appears the Part B Trust Fund contingency level should to be maintained in the range of 0–5% of the following year's expenditures, and the rates are set to maintain that level. This policy would not change if the 25% requirement were extended.

Question 14. In negotiating the administration on the drug benefit, we agreed that the drug insurance trust fund would need to be financed so as to achieve significant contingency margins, and that initially those would be as high as 75 percent or 175 percent of total reserves. Taking into account the administration's estimate of drug spending, would you consider a 75 percent margin sufficient? And what levels of flat and supplemental premiums would be required to achieve a 75 percent reserve?

Answer. Yes, at this point a 75 percent reserve is prudent. Clearly, there are uncertainties inherent in projecting costs of a new benefit; and we must allow enough of a margin so that claims can be paid in the event that program costs exceed original projections. As the program matures and we become more assured of the benefit levels and expenditures, the contingency margin can be reduced to a much more modest level. However, I must caution that our actuaries believe that claims for as much as 16 percent of a calendar year's benefits will be filed in January of the following year, which makes a 20 percent December cash margin (the ultimate reserve specified in the law) a perilously thin safety factor.

To achieve a 75 percent margin in 1991, we would need to raise premiums by $1.9 billion. Another $2.3 billion increase would be needed in 1992 to achieve a 75 percent margin, and yet another $200 million in 1993 to achieve a 50 percent margin.

Question 15: As the Committee on Finance considers the financing of catastrophic insurance as well as continues deliberations over the FY 1990 budget, we are missing one vital source of information: the Annual report of the Board of Trustees of the Medicare Hospitals Insurance (Part A) Trust Fund, which was due on April 1st. Can you tell me why the report has been delayed? When can we expect it?

Answer. The Annual Report for the Supplementary Medical Insurance program was submitted to the Congress on April 24, 1989. The Annual Report of the Board of Trustees for the Hospital Insurance (HI) program has been delayed because the financial status of the HI program is now intertwined with the financing of the new catastrophic benefits. The Trustees are required to report on the income to the HI program as well as the income to the HI Catastrophic Coverage Reserve Fund. To assess the adequacy of the catastrophic fund, it is necessary to include Treasury Department revenue projections from the income tax-based supplemental premium.

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[1] N.L. Bowers, *et al., Actuarial Mathematics,* Society of Actuaries, 1986, pp. 336–341.

[2] Arleen Leibowitz et al., *A RAND Note: The Demand for Prescription Drugs as a Function of Cost Sharing,* N-2278-HHS, October 1985, p. 12.

[3] Bowers, *op. cit.,* pp. 336-341.

The Report of the Board of Trustees for HI and the Catastrophic Coverage Reserve Fund will be finalized and submitted to the Congress approximately 2 to 3 months after the information necessary to complete the 75 year projections of the income-related revenue becomes available from the Treasury Department.

RESPONSES OF LOUIS W. SULLIVAN TO QUESTION SUBMITTED BY SENATOR HEINZ

Question. There are a number of provisions in the catastrophic drug benefit specifically to limit cost increases:

- limits on multiple source and single source drugs;
- limits on prescription supplies;
- a fairly high deductible; and
- a drug utilization review program.

In view of these safeguards, why are you certain the cost is going to be as high as you think? Did you, for example, take into account the effect of a drug utilization review system?

Answer. While these safeguards have been built into the catastrophic drug benefit and our estimates, the following factors will have influence on the cost of the program: First, Medicare payment for drugs is based on the listed average wholesale price, over which we have no control. Second, as we limit supplies by breaking a 60-day prescription into two 30 day prescriptions, the savings through reduced waste will partly be offset by increased administrative costs. Third, the size of the deductible will reduce, but not eliminate, the potential insurance effect of the program which would encourage more use because insurance will pay. Fourth, to the extent that existing drug utilization review programs have altered the trend in consumption of drugs by the aged, we have included such effects in our estimates. However, it is not fiscally prudent to ascribe significant savings to a national program that has yet to be implemented.

PREPARED STATEMENT OF SENATOR STEVE SYMMS

Since the Senate passed the Medicare Catastrophic Protection Act a year ago, I have heard from literally hundreds of constituents opposing the new law. In fact, with the possible exceptions of the Panama Canal and withholding of interest and dividends, I cannot remember when I have received such a tremendous response on a single issue.

This bill, at a cost of over $29 billion for the first five years, constitutes the single largest expansion of a federal social welfare program since Medicare was created in 1965. And, aside from the fact that our senior citizens are paying a rather large tax on benefits they neither want nor need, we have now discovered that the law will cost more than was anticipated.

During Congress' deliberation on the legislation, the seniors somehow arrived at the conclusion that with this Catastrophic insurance, they would no longer need supplemental insurance to fully cover their needs. This was a misconception. Yet, many canceled other health insurance policies only to find that the new law not only did not cover them adequately, but it cost far more than a second insurance policy. why should our seniors be required to pay this catastrophic premium when they could easily find a less expensive policy that takes care of their true needs such as long term care?

We are all aware of the devastating effects long-term care can have on those suffering from catastrophic illnesses, yet this bill does not address that issue. Instead, the Catastrophic Protection law puts our seniors among the highest taxed citizens in America.

Since the passage of the Catastrophic Protection law, I notice that several bills have been introduced to repeal parts of it, delay part or all of it, or to set up a task force or commission to study the needs of the elderly. At this point, I believe more studies are unnecessary. We know what the senior citizens need—they have been telling us since last June. The bottom line is that the Catastrophic Protection law is not working.

I would like to see Congress start from the beginning to resolve this situation—maybe we can get it right this time.

PREPARED STATEMENT OF HON. THOMAS J. TAUKE (R-IOWA)

Mr. Chairman, I commend you for convening this hearing on the Medicare Catastrophic Coverage Act in response to the depth of concern that this new law has provoked among the elderly of this nation. I am sure that most members of Congress are experiencing what I have since the passage of the law and dissemination of information about it: expressions of deep concern about this law dominate the constituent letters and calls flooding into my office, my personal conversations with my elderly constituents, and my town meetings.

We are not just hearing from a few "disgruntled" senior citizens; we are hearing from the majority of the elderly. A recent Wirthlin Group poll shows seniors oppose the act by 53 percent to 31 percent. In my own Congressional poll, taken in March, Eastern Iowans opposed the act 63 percent to 20 percent.

They are right to be concerned. While well-intentioned, the Medicare Catastrophic Coverage Act has serious flaws. We need to rethink and restructure this law to ensure that it lives up to the good intentions we all started with in framing the law. What our elderly want is sound health policy and sound retirement policy. The Medicare Catastrophic Coverage Act as it is now structured is neither.

The vote on this law was not an easy one for me. I strongly support providing protection against catastrophic medical costs for all of our citizens and certainly for the elderly. No senior citizen should be forced into abject poverty by the high cost of medical care. No senior citizen should be forced to choose between buying medicine and buying enough food. I co-sponsored the original version of the Medicare Catastrophic Coverage Act, providing enhanced protection against hospital costs. I coauthored the spousal impoverishment protections in the final law. I voted for a version of this legislation which would have provided enhanced home health care coverage, enhanced hospitalization and skilled care coverage, drug coverage for the elderly with modest incomes who did not qualify for Medicaid, and protection against impoverishment when a spouse enters a nursing home. This version of catastrophic protection was financed by a modest increase in the Medicare Part B premium and through general state and Federal revenues for Medicaid.

But I could not support and voted against the final version of this law as developed by the House of Representatives and as reported by the House/Senate Conference Committee. Let me outline what I see as the most serious problems with the law:

(1) It duplicates coverage that many elderly have as part of their employer-provided retirement plans. Retirees who earned this coverage through their years of labor are now being forced to pay for what was once provided to them by their employers. Many retirees faced a choice during their working years or upon retirement of higher pensions and lower or no retirement health benefits or lower pensions and health coverage. Those who chose the latter option are now particularly unfairly hit by the Medicare Catastrophic Coverage Act.

(2) The elderly will pay the lion's share of the income surtax financing the new benefits, but younger, disabled persons will receive the greatest benefit. I support providing catastrophic coverage for the disabled, but I believe the cost of this coverage should be shouldered by society as a whole, not by the elderly alone. If we were setting out today to design such a benefit, would we decide to finance it largely by taxing only the elderly who had saved independently for retirement? That is precisely what the Medicare Catastrophic Act does.

(3) The new law is poor retirement income policy. Taxing those who have saved independently for retirement, often at considerable sacrifice during their working years, is inequitable and sends exactly the wrong signal to today's workers about the importance of savings and investments for the future. We cannot afford to send this signal when we know that the demographics of a shrinking workforce and a growing percentage of retired persons will put serious strains on Social Security.

(4) The new law puts an unconscionable tax burden on the working elderly. The combination of income taxes, the Social Security offset for income, and the Catastrophic income surtax create effective marginal tax rates in excess of 100 percent for some elderly workers.

(5) For many of the elderly, the income surtax combined with the taxation of Social Security benefits reverses the lowering of marginal tax rates under the Tax Reform Act.

(6) In choosing to finance the drug benefit through Medicare, we are faced with establishing a costly new bureaucracy to administer it. In fact, some studies I have seen indicate that nearly half the cost of the drug benefit will be for administering it—equipping providers with the costly software and hardware necessary to track every prescription purchase by every Medicare beneficiary. Under Medicaid we al-

ready have a system in place for drug coverage for those most in need of assistance. It would have been far more sensible to gradually expand coverage under this system for the elderly, rather than create an entirely new, duplicative, and costly system.

(7) Nothing in the Catastrophic Act addresses the spiraling inflation in health care costs we are experiencing. In fact, the new law is likely to fuel inflation. Consider the fact that this year, premiums for Medicare supplemental policies rose substantially instead of leveling off or falling.

(8) Finally, with the exception of the spousal impoverishment provisions and a modest increase in home health care coverage, the new law fails to address the catastrophic cost the elderly most fear—long-term care.

Congress can and must do better than this. We need to take this bill back to the shop. A good first step would be the enactment of H.R. 1564 (S. 335), legislation Senator McCain and I have introduced to put the surtax on hold for a year and delay the implementation of benefits not yet in effect, with the exception of spousal impoverishment protection, to give us the time we need to produce catastrophic coverage that is sound health policy and sound retirement policy.

Prepared Statement of Senator Malcolm Wallop

Mr. Chairman, I seem to have become an ex officio member of this Committee with all the appearances I am making lately. I think the only hearings I have not been to were on rural health care. However, my interest in rural health is just as keen as the other issues which are coming before this Committee. I will be following closely your work on rural health this year, and your activities regarding a new reimbursement procedure for physician services under Medicare which will impact rural health services.

If recent calculations by the Health Care Financing Administration are accurate the physicians in my State of Wyoming would finally receive adequate reimbursement for services if we legislative a RB-RVS approach for physician services. Adequate reimbursement has been a major problem in my largely rural State. Since Medicare reimbursements in Wyoming trail those in surrounding States, we have encountered some difficulties in attracting new physicians. A more equitable payment reform will improve physician recruitment for Wyoming. And, it will mean that we will be able to provide new benefits such as the catastrophic coverage.

Today, our attention is focused on the catastrophic benefit issue. The question is whether the supplemental premium should be reduced. Over the past few months, every Senator has been deluged with mail from senior citizens expressing displeasure with the catastrophic health premium. This is a vastly different situation than when we passed the bill. It was the first major expansion of the Medicare program since 1965, and it was financed by those who benefited from the new coverage.

The supplemental premium, which institutes a means test for this Social Security benefit, has been the lighting rod for discontent. I am not certain that a roll back in the premium is wise, especially if we are going to maintain all the new benefits. To reduce premiums without changing benefits may trap us into having to use general revenues to ensure proper funding of the catastrophic benefit. As the history of the Part B premium indicates, this is an all to likely scenario.

If we reduce premiums, we should also freeze benefits at this year's level. Another alternative is to make the program voluntary. The original Senate version was technically a voluntary provision. It was tied to Part B. During the floor debate, I offered an amendment which would have made the catastrophic benefit a separate voluntary benefit. Though we were defeated, it is now obvious that we have not as yet lost the war. Controversy surrounds the new benefit mainly because we were forced to accept language from the House of Representatives, which required the program to be mandatory.

I have reintroduced my amendment as a new bill, S. 608. If we were to make the program voluntary, as I have proposed, there would be some dropouts. The Part B voluntary participation rate is 95% of all eligibles, and I would expect a similar participation rate for the Catastrophic Health Benefit. People will realize that this is an important benefit and they will seek it. I come from the perspective that voluntary inclusion rather than government coercion is always the best public policy and this philosophy should be applied to the new catastrophic benefit.

It is ironic that those who have chosen not to participate in Part B of Medicare will not have to pay the basic premium for the catastrophic benefit, about $4 a month. However, if they have any income tax obligation, they will be subject to the

Supplemental Premium. It is a rather odd method for structuring the financing of this benefit. It is not well balanced.

Despite this awkward structure, the program does involve several important principles which must be maintained. We have established that the user pays for the benefits. The program also has a means test—a flawed test in that it is applied only to the payment of the premium and not to the receipt of benefits.

I am convinced that the major remaining problem is not the size of the basic or the supplemental premiums, but that the program is not voluntary. Simply reducing the supplemental premium does not resolve any of the problems with the program. We have fallen into this trap before of tinkering with the financing or the benefits in the Social Security programs due to rosy predictions of a future overabundance in the trust fund. The report of the trustees on the Health Insurance trust fund, which we still have not received, may provide useful projections on whether there is a looming surplus in the trust fund. The last annual report, before the catastrophic benefit was included, did predict financial stress in the trust fund. I would like to know how things stand today.

In closing, it is interesting that we are being told that people do not want a new government benefit. This may be a new phase of public policy, with people confronted with the actual cost of the benefits and having to decide whether the cost is worth the benefit. My solution is to make the benefit voluntary. We should not merely cut the funding of what will eventually be an expensive benefit. We should let senior citizens decide whether the benefit is worthwhile by making it voluntary. Thank you for allowing me to appear again before your Committee.

PREPARED STATEMENT OF RICHARD WARDEN

Mr. Chairman, my name is Dick Warden, Legislative Director of the UAW. I am accompanied today by Alan Reuther, UAW Associate General Counsel. We are pleased to have this opportunity to share with you and your Committee our views with respect to the Medicare Catastrophic Protection Act particularly the financing mechanism for that Act.

This statement is submitted on behalf of the International Union, United Autombile, Aerospace and Agricultural Implement Workers of America (UAW). The UAW represents I million active and 500,000 retired workers and their families, most of whom are covered under negotiated health benefit programs. These health benefit programs typically provide supplementary, "wrap-around" health coverage to post-65 retirees who are enrolled in Medicare.

The UAW commends you, Mr. Chairman, for holding hearings on the financing of benefits provided under the Medicare Catastrophic Protection Act. The UAW believes that the manner in which those benefits are financed should be changed. We strongly support the legislation which we understand Senators Harkin and Levin and Representative Bonior will be introducing which would completely repeal the surtax on the elderly, replace it with general revenues and raise those general revenues by extending the existing 33 percent tax bracket to very wealthy taxpayers. We urge this Committee and the Senate to give this legislation prompt, favorable consideration.

Mr. Chairman, you have expressed concern about estimates from Treasury, the Joint Tax Committee and CBO which show that revenues expected to be raised by the surtax on the elderly under the Medicare catastrophic program may be larger than originally projected. These new estimates indicate that the surtax will provide more revenues than are needed to pay for the catastrophic benefits, including the reserves which were agreed to by Congress and the Reagan Administration when the program was enacted. It appears that the surtax will actually generate a substantial surplus.

We agree with the Chairman that this is unfair. If the surtax is not changed, it means that the elderly will not only be paying for the entire cost of the catastrophic benefits. They will also be paying a special surtax to help reduce the overall federal deficit. The federal budget deficit is the responsibility of the entire country. It is wrong to place a special surtax on the elderly, part of which will be used to reduce the deficit.

President Bush has indicated that he is opposed to any modification in financing the Medicare catastrophic program. To defend this position, he has fallen back on the argument that the future cost of the program is uncertain, and that larger reserves are needed to provide an appropriate margin of safety. But this argument conveniently ignores the fact that Congress and the Reagan Administration agreed on a specific level of reserves when they enacted the Medicare Catastrophic Protection Act. There is no basis in the law for the Administration to change the reserve requirements.

If the Committee decides to modify the surtax on the elderly to eliminate the projected surplus, the UAW urges you to do it in a progressive manner. The fairest approach would be to reduce the tax rate in the surtax, or to increase the threshold at which the surtax is imposed. We strongly oppose any effort to simply lower the cap on the surtax. This would give a small measure of relief to the wealthiest senior citizens, but would do nothing for the millions of middle income seniors who are currently subjected to the surtax.

The UAW firmly believes, however, that tinkering with the surtax will not solve the underlying problem in the financing mechanism far the Medicare Catastrophic Protection Act. We object to the principle underlying the financing mechanism—namely, that the catastrophic benefits have to be paid for entirely by the elderly. This principle was incorporated into the law because President Reagan insisted at the outset that any new Medicare benefits would have to be paid for by senior citizens themselves.

Requiring the elderly to pay for the entire cost of the catastrophic benefits is, in our judgment, wrong for several reasons. Most importantly, it violates the social insurance principles that underlie Social Security and Medicare. In particular, the Medicare Part B program has long been financed three quarters from general revenues, one quarter through premiums paid by the beneficiaries. The manner in which the catastrophic benefits are financed represents a sharp break with the past. We fear that it could establish a dangerous precedent undermining Medicare and Social Security in the future.

Furthermore, the UAW is concerned that it could also establish a precedent for other federal programs. We do not believe that farmers should be required to pay for the entire cost of farm support programs; that students should have to pay for the entire cost of student loan programs, or that families with children should have to pay for the entire cost of child care programs. The nation as a whole should share the burden of paying for these essential programs. But if the financing mechanism in the Medicare catastrophic program is not changed, there may be pressure to extend the same principle to other federal programs. That, in our view, would be most regrettable.

Finally, requiring the elderly to pay the entire cost of the catastrophic benefits results in middle and upper income senior citizens shouldering the entire burden of paying for the subsidies for lower-income seniors. This is unfair. This burden should properly be shared by all of society, not just the more fortunate segment of the elderly.

Because this burden is placed exclusively on middle and upper income seniors, they wind up paying premiums and taxes which are many times the value of the benefits provided under the Medicare catastrophic program. The actuarial value of the catastrophic benefits has been estimated by the Health Care Financing Administration to be $65 per Medicare beneficiary in 1989. The actuarial value is projected to be approximately $166 in 1990, and $322 in 1993 when the benefits are fully phased in. But under the Medicare catastrophic program, senior citizens can be required to pay as much as $848 in basic and supplemental premiums (i.e., flat premium plus the surtax) in 1989. This rises to $908.80 in 1990, and to $1,172.40 by 1993. Clearly, many senior citizens are not getting a good deal under the Medicare catastrophic program.

Some argue, however, that the elderly still get a good deal under the Medicare program. It is true that the benefits under the Medicare Part B program are heavily subsidized for all senior citizens, since three quarters of the program is financed through general revenues. The Reagan Administration repeatedly proposed that this subsidy be reduced. The UAW and other labor and senior citizen organizations strongly opposed these proposals, and Congress always rejected them. We do not believe that Congress intended to take away this subsidy through the back-door when it adopted the system for financing the catastrophic benefits which requires middle and upper income seniors to pay premiums and taxes far in excess of the value of those benefits.

The unfairness in the financing mechanism for the Medicare catastrophic program is compounded by the fact that many senior citizens already had most of the catastrophic coverage paid for by their former employer. This includes many UAW retirees covered under our collective bargaining agreements with the major automobile, aerospace and agricultural implement companies. The net result of the catastrophic legislation was to provide these companies with an enormous windfall, and to shift the cost of providing these catastrophic benefits to retirees themselves.

In an effort to address this problem, the Medicare Catastrophic Protection Act contains the so-called "maintenance-of-effort" provision. This provision basically states that if an employer was previously providing the catastrophic benefits to its retirees, then the employer will be required for a limited period of time either to provide additional benefits or to pay a rebate to the retirees equal to the value of the duplicative benefits. Although the "maintenance-of-effort" provision will provide some relief, it does not solve the entire problem. To begin with, this provision is only temporary. Furthermore, there will still be many cases where the basic and supplemental premiums owed by retirees will exceed the value of any rebate or additional benefits paid by their employer. Thus, these retirees will still be worse off than they were before enactment of the catastrophic program.

In our judgment, the legislation which we understand will be introduced by Senators Harkin and Levin and Representative Bonior represents the best approach towards reforming the financing mechanism in the Medicare catastrophic program. This legislation would retain all of the benefits added under the catastrophic program. It would also keep the flat premium which is paid by senior citizens to help finance the catastrophic benefits. However, the bill would completely repeal the supplemental, income-related premium (i.e., the surtax) which was imposed on the elderly and would replace that surtax with general revenues. In order to raise sufficient general revenues to pay for repealing the surtax, the bill would extend the existing 33 percent tax bracket to very wealthy individuals.

The approach adopted by the Harkin-Levin-Bonior bill is consistent with the social insurance principles which have formed the basis for Social Security and Medicare. Under the bill, the Medicare catastrophic program would be financed in much the same manner as the Medicare Part B program that is, through a combination of general revenues and flat premiums paid by all Medicare beneficiaries.

Under the Harkin-Levin-Bonior bill, senior citizens would not be given a free ride. They would still be required to pay the flat premiums to help finance the catastrophic program. These premiums are $4 per month in 1989, and will rise to $10.20 per month in 1993 when the program is fully phased in. Through these premiums, seniors will be paying approximately 40 percent of the costs for the catastrophic benefits. This is significantly higher than the percentage of the costs of the Medicare Part B program (i.e., 25 percent) which is paid for by senior through flat premiums.

However, by substituting general revenues for the surtax on the elderly, the Harkin-Levin-Bonior bill would eliminate the inequity in the present law under which middle and upper income seniors are required to carry the entire burden of subsidizing the cost of catastrophic benefits for lower income seniors. Instead, the burden would be shared by all of society. As a result, middle and upper income seniors would no longer be required to pay premiums and taxes substantially greater than the value of the catastrophic benefits.

Extending the existing 33 percent tax bracket to wealthy taxpayers will not undermine the rate structure established under the Tax Reform Act of 1986. In fact, it will actually help to reinforce that rate structure. The Tax Reform Act of 1986 *already* imposes a 33 percent tax rate on some taxpayers. Married couples with two dependents filing jointly pay a 33 percent tax rate if their income is between $78,350 and $208,510; a single individual pays a 33 percent tax rate if his or her income is between $47,000 and $109,050. However, the tax rate drops back to 28 percent for taxpayers earning above these amounts. This violates the basic principle of progressive taxation. In effect, wealthy individuals are taxed at a lower rate than persons making less money. The bill would correct this inequity by simply extending the existing 33 percent bracket so that it also applies to very wealthy taxpayers.

It is worth noting that the surtax on the elderly under the catastrophic program violates the rate structure established by the Tax Reform Act of 1986. As a result of the surtax, middle and upper income seniors have to pay higher tax rates than the rest of the population. By repealing the surtax, the bill would make sure that senior citizens pay the same tax rates as everyone else.

Taken as a whole, the Harkin-Levin-Bonior bill actually represents a tax *reduction* measure. Under the Medicare catastrophic program, approximately 13 million senior citizens are subjected to the income tax surcharge. By eliminating this surtax, the Harkin-Levin-Bonior bill would substantially lower taxes for these individuals.

It is true that the bill would require very wealthy individuals to pay higher taxes. CBO has estimated that only the wealthiest 600,000 taxpayers would be affected by this change. These taxpayers, however, would simply be required to pay the same tax rate as persons making less money than them.

In addition to the changes proposed in the Harkin-Levin-Bonior bill, the UAW also believes that the maintenance-of-effort provision in the Medicare Catastrophic Protection Act needs to be improved. At the very least, this temporary provision needs to be extended. Currently the maintenance-of-effort obligation only applies for one year for the Part A improvements, and one year for the Part B improvements (excluding prescription drugs), or until the end of an existing collective bargaining agreement. In most situations, this means that after the passage of one year employers will begin to reap an enormous windfall, and the costs of providing the catastrophic benefits will be shifted to retirees.

To prevent this from occurring, we believe that the maintenance-of-effort obligation should be extended. The obligation should apply to all duplicative benefits provided under Medicare Part A, Part B, and the new prescription drug program. Moreover, the obligation should apply to all individuals covered under the employer- sponsored retiree health program who have the duplicative coverage, not simply individuals who retired prior to the date the catastrophic program was enacted. We also believe that the law should be amended to make it clear that any maintenance-of-effort payments are not subject to federal income and F1CA taxes.

A number of bills have been introduced to repeal the Medicare Catastrophic Protection Act entirely, to impose a moratorium on further implementation of the law, or to cut-back on the benefits provided under the catastrophic program. The UAW strongly opposes all of these proposals. The benefits provided under the catastrophic program are extremely valuable and should be preserved.

The Medicare Catastrophic Protection Act takes a number of important steps which have long been advocated by the UAW and other groups to close gaps in the coverage provided under Medicare. As a result of the new law, Medicare now provides 365 days of hospital coverage per year, with no coinsurance and only one deductible. Medicare will also pay for all approved fees for physician services after a patient has paid a maximum of $1,370 per year. And, for the first time, Medicare will help pay for a portion of out-patient prescription drugs costs.

To be sure, there is still room for additional improvements in Medicare. But while we will continue to press for improvements, we should not lose sight of the important progress which has been made.

Prior to enactment of the catastrophic program, many private employers provided these same benefits to their retirees. The federal government also provided these benefits to federal retirees. And many individuals purchased their own private Medigap policies to provide these benefits. Obviously these benefits were viewed by many employers and individuals as being extremely important.

But employer-sponsored benefit programs can never be as secure as a public program. There is always the danger that a private employer will go bankrupt. Retirees at LTV and Allis-Chalmers found this out the hard way when their employers filed for bankruptcy and the entire health packages of thousands of retirees were placed in jeopardy.

Furthermore, individual Medigap policies repeatedly have been shown to be much less cost effective than public programs. Typically these private policies only return about 60 cents of benefits for each dollar of premiums. Widespread abuses have also been documented in the marketing of these private policies.

It is also important to remember that approximately one-fifth of the elderly - primarily lower income seniors—did not have any catastrophic coverage prior to passage of the Medicare Catastrophic Protection Act. These persons simply could not afford to purchase coverage on their own. And they were not covered under any employer-sponsored retiree health programs. For these individuals, the Medicare catastrophic program represents the only means of obtaining this important health coverage.

Some persons have complained that only a few people will benefit from the catastrophic program. That is not true. Approximately 22 percent of Medicare enrollees (about 7.8 million persons) will actually collect catastrophic benefits each year once the program is fully implemented. Furthermore, all senior citizens will gain the additional security of knowing that they are protected against the potentially devastating costs of catastrophic illnesses.

Others have criticized the new law on the grounds that it does not cover long-term care. That is not totally true. The catastrophic legislation will provide over $1 billion per year in new nursing home, home health and respite care services by 1993. And the new law also addresses the problem of "spousal impoverishment" that is, forcing a husband or wife to "spend down" to the poverty level in order for the spouse in a nursing home to qualify for Medicaid—by allowing the husband or wife to retain more income and assets.

The new law does not provide protection against most of the huge costs associated with home care or custodial nursing home care. The UAW supports the development of a comprehensive long-term care program which will address these important needs. But the Medicare catastrophic program at least takes a first step towards addressing the long-term care needs of senior citizens.

In conclusion, Mr. Chairman, the UAW appreciates the opportunity to present our views on the Medicare Catastrophic Protection Act, and in particular, on the manner in which the program is financed. We believe that the Harkin-Levin-Bonior bill represents the best approach toward correcting the inequities in the current financing mechanism. We look forward to working with you and other Members of the Committee as you consider the various options for dealing with this important issue. Thank you.

Prepared Statement of John G. Wilkins

Mr. Chairman and Members of the Committee:

I am pleased to be here today to present the views of the Department of the Treasury regarding revenues to be collected under the Medicare Catastrophic Coverage Act (the "Act"). My statement today is limited to explaining the estimates of the income-related supplemental premium revenues that are the responsibility of the Treasury Department's Office of Tax Policy.

BENEFIT FINANCING UNDER THE ACT

Program benefits are financed under the Act by both flat fees and income-related supplemental premiums. The structure of the Act that gives rise to these receipts is as follows:

Catastrophic

—Flat monthly fee. In general, Medicare Part B enrollees are required to pay an additional flat fee of $4.00 per month (equivalent to $48.00 per year) in 1989, $4.90 per month (equivalent to $58.80 per year) in 1990, $5.46 per month (equivalent to $65.52 per year) in 1991, $6.75 per month (equivalent to $81.00 per year) in 1992, and $7.18 per month (equivalent to $86.16 per year) in 1993.

—Income-related supplemental premium. In addition, Medicare-eligible individuals who pay Federal income tax are required to pay an income-related supplemental premium. The premium rate is $22.50 per $150 of adjusted Federal income tax liability in 1989. The premium rate per $150 of adjusted liability will be $27.14 in 1990, $30.17 in 1991, $30.55 in 1992, and $29.55 in 1993. (These figures may vary in the case of certain individuals, such as individuals who receive Government pensions.)

Prescription Drugs

—Flat monthly fee. In general, Medicare Part B enrollees are required to pay an additional flat fee beginning in 1991 of $1.94 per month (equivalent to $23.28 per year) in 1991, $2.45 per month (equivalent to $29.40 per year) in 1992, and $3.02 per month (equivalent to $36.24 per year) in 1993.

—Income-related supplemental premium. In addition, Medicare-eligible individuals who pay Federal income tax are required to pay an income-related supplemental premium. The premium rate is $10.36 per $150 of adjusted Federal income tax liability in 1990. The premium rate per $150 of adjusted liability will be $8.83 in 1991, $9.95 in 1992, and $12.45 in 1993. (These figures may vary in the case of certain individuals, such as individuals who receive Government pensions.)

Overall Income-Related Supplemental Premium Limitations

—In general, a maximum annual income-related supplemental premium is established by an overall ceiling per enrollee of $800 in 1989, $850 in 1990, $900 in 1991, $950 in 1992, and $1,050 in 1993.

—In general, individuals with income tax liabilities under $150 are not required to pay income-related supplemental premiums.

ADMINISTRATION ESTIMATES

In June 1988, at the time of enactment of the Medicare Catastrophic Coverage Act, the Administration estimated that receipts from the Act would total $37.4 billion over a 5-year period, fiscal years 1989–1993. These receipt collections include both the flat premiums and the income-related supple mental premiums for the basic catastrophic part of the program as well as for the drug part. Flat premiums were estimated by the Department of Health and Human Services and income-related supplemental premiums were estimated by the Department of the Treasury. Treasury's year-by-year estimates of income-related supplemental premium payments are shown on Table 1.

Coupled with the Department of Health and Human Services' estimates of spending on new benefits under the Act, the $37.4 billion of receipts through fiscal year 1993—including $24.0 billion in income-related supplemental premiums—gave rise to an Administration estimate of a $2.1 billion fund balance at the end of fiscal year 1993. That may be compared with the $4.2 billion fund balance estimated by the Congressional Budget Office at that time, which estimate was the official estimate for congressional consideration. The Administration and Congress were in agreement that a surplus was important to avoid under-funding in order to protect the beneficiaries of the program.

Estimates of income-related supplemental premium payments under the Act were revised by the Treasury for the President's Budget for fiscal year 1990. The revised estimates reflect Administration expectations that receipts from the Act will now total $41.7 billion for this same 1989–1993 5-year period, a $4.3 billion increase over the original estimate. These revised estimates include $28.3 billion of income-related supplemental premiums, also shown on Table 1.

Coupled with the Department of Health and Human Services' current projection of spending on benefits under the Act, our current estimate gives rise to a $6.2 billion fund balance at the end of fiscal year 1993. This is a fund balance increase of about $4.1 billion over the original Administration estimate and about $2 billion over the original congressional estimate.

REASONS FOR REVISION

The revision in the Administration's estimate between June 1988 and January 1989 occurs entirely in the income-related supplemental premiums. The estimate of the flat premiums remains unchanged at $13.4 billion. Our estimate of the income-related supplemental premiums was increased from $24.0 billion to $28.3 billion; however, almost all of this revision is attributable to a revised estimate of the speed with which the premiums will be collected and very little is attributable to a change in the liability of affected taxpayers. This is illustrated by the fact that the January 1989 calendar year liability estimates shown on the lower half of Table 1 are almost identical to the estimates of calendar liabilities prepared in June 1988. The very small differences—no larger than $200 million in any year—are associated with changes in the underlying macroeconomic forecast and other technical factors.

The original June 1988 estimate assumed that a relatively small fraction of the additional premium would be paid in the form of quarterly estimated taxes and, to a lesser extent, in the form of withheld income taxes. The January 1989 estimate reflects a reappraisal of the use of quarterly estimated taxes and withheld taxes by elderly taxpayers who would make additional payments under the Act's income-related supplemental premium provision. This change in the assumed form of payment results in a speedup of collections and accounts for virtually the entire increase in receipts over the 5-year period.

Computer analysis of tax returns filed by those who may be required to pay income-related supplemental premiums shows that more than three-fourths currently pay quarterly estimated tax payments or have income tax withheld from pension or wage income. About 85 percent of income tax payments made by the elderly population occur in the form of estimated and withheld payments.

We believe it is reasonable, therefore, to assume that in order to avoid penalties somewhere between 80 and 90 percent of the income-related supplemental premium payments will be reflected in "current" tax payments, that is, quarterly estimates or withheld taxes, and that only the remaining 10 to 20 percent will be reflected in larger final payments or smaller refunds.

This payment pattern, however, does not apply to the first 2 years of the program. The law specifically waives the estimated tax requirement with respect to income-related supplemental premiums due for 1989. Thus, in that year we assume that only about 15 percent of the income-related supplemental premiums will be reflected in current tax payments. For 1990, we estimate that the fraction of income-related supplemental premiums that will be reflected in estimated or withheld payments will increase only to about two-thirds because many taxpayers will benefit in that year from the general safe harbor rule that estimated payments need not exceed 100 percent of the prior year's liability.

Treasury completed this analysis after revenue estimates were made at the time of the conference report. In June 1988, our estimates were consistent with about three-fourths of the premium payments showing up in year end settlements.

DIFFERENCES FROM CBO ESTIMATES

A comparison of the current Treasury revenue estimate of the income-related supplemental premium payments under the Act with the current Congressional Budget Office estimate shows that Treasury anticipates collections over the 5-year budget period, fiscal years 1989–1993, to be $2.4 billion greater than does CBO. These estimates are shown on Table 2. However, a comparison of Treasury and CBO estimates of calendar year liabilities associated with income-related supplemental premiums (lower half of Table (2) shows that Administration and congressional liability estimates are quite similar. In two of the five years, 1989 and 1990, there is virtually no difference and in only one year, 1993, is the difference between the two offices' estimates as great as $500 million, a difference of about 7 percent.

This demonstrates that the existing difference between Treasury's estimate of $28.3 billion in income-related supplemental premiums and CBO's estimate of $25.9 billion is attributable to different assumptions concerning the payment of premiums and not to fundamental differences in the amount of premium liability. For reasons I have explained, we believe that our current estimates accurately reflect the requirements of the estimated tax system and incorporate a more complete understanding of taxpayer behavior.

CONCLUSION

The Reagan Administration supported the Medicare Catastrophic Coverage Act of 1988 when it was enacted and the Bush Administration remains committed to its implementation. The Department of the Treasury has reviewed the data and model used to estimate the receipts under the Act and finds no reason to change the estimates made last winter.

Although our current income-related supplemental premium liability estimates are not substantially different from those made by CBO, the Administration's estimate of actual revenue collections under the Act are $2.4 billion greater than those made by CBO. The Administration's $6.2 billion estimate of the overall fund balance at the end of 1993 is not sufficiently large in our judgment, however, to warrant altering the structure of the program's funding mechanism. Treasury would not consider it prudent to alter the premium structure until we have sufficient experience to validate estimates of revenues and spending made by the Administration and by CBO. There is general agreement that a cushion is required to assure that promised benefits will in fact be available. Given the uncertainty inherent in making projections in the absence of significant actual experience and in view of Secretary Sullivan's concern that the drug fund may be substantially underfunded, we believe that changing the level of funding now would not be consistent with protecting the rights of beneficiaries.

Mr. Chairman, that concludes my formal statement. I will be happy to answer questions that you and Members of the Committee may wish to ask.

TABLE 1.—MEDICARE CATASTROPHIC COVERAGE ACT—SUPPLEMENTAL PREMIUM RECEIPTS AND LIABILITY—COMPARISON OF TREASURY JUNE 1988 ESTIMATES AND TREASURY 1990 BUDGET ESTIMATES

[Billions of dollars]

	Year					Total
	1989	1990	1991	1992	1993	(1989–93)
Fiscal year						
June 1988	0.4	4.5	5.9	6.3	6.9	24.0
1990 Budget	0.6	6.5	7.1	6.9	7.3	28.3
Difference	0.2	2.1	1.2	0.6	0.3	4.3
Calendar year						
June 1988	3.9	5.7	6.2	6.8	7.4	30.0
1990 Budget	4.1	5.9	6.4	6.9	7.4	30.7
Difference	0.2	0.2	0.2	0.1	0.0	0.7

TABLE 1.—MEDICARE CATASTROPHIC COVERAGE ACT—SUPPLEMENTAL PREMIUM RECEIPTS AND LIABILITY—COMPARISON OF TREASURY JUNE 1988 ESTIMATES AND TREASURY 1990 BUDGET ESTIMATES—Continued

[Billions of dollars]

	Year					Total
	1989	1990	1991	1992	1993	(1989–93)

Department of the Treasury Office of Tax Analysis, June 1, 1989.

TABLE 2.—MEDICARE CATASTROPHIC COVERAGE ACT—SUPPLEMENTAL PREMIUM RECEIPTS AND LIABILITY COMPARISON OF TREASURY 1990 BUDGET ESTIMATES AND CBO 1990 BUDGET ESTIMATES

[Billions of dollars]

	Year					Total
	1989	1990	1991	1992	1993	(1989–93)
Fiscal year						
Treasury	0.6	6.5	7.1	6.9	7.3	28.3
CBO	0.4	5.4	6.1	6.7	7.3	25.9
Difference	0.1	1.1	1.0	0.2	−0.1	2.4
Calendar year						
Treasury	4.1	5.9	6.4	6.9	7.4	30.7
CBO	4.1	5.9	6.5	7.1	7.9	31.5
Difference	0.0	0.0	−0.1	−0.2	−0.5	−0.8

Department of the Treasury, Office of Tax Analysis, June 1, 1989.

PREPARED STATEMENT OF MICHAEL ZIMMERMAN

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss the work we have done for the Congress on Medicare Supplement, or Medigap, insurance policies and how they may be affected by the Medicare Catastrophic Coverage Act of 1988. You asked that we specifically cover how Medicare benefits change under the Catastrophic Act, how these changes will affect Medigap policies, and what percentage of Medigap premiums has been returned as benefits (that is, loss ratios) over the years.

In summary, the Catastrophic Coverage Act added significant new benefits to Medicare for beneficiaries who require a substantial amount of health care in any given year. Starting in 1990, these new benefits will substantially decrease the potential liability of beneficiaries and their Medigap policies. About half of the commercial policies and about 10 percent of the Blue Cross/Blue Shield plans for which we have the most recent data had loss ratios below the federal target amounts.

MEDICARE AND MEDIGAP

Medicare, authorized by title XVIII of the Social Security Act, provides coverage for a broad range of health services for most people 65 years of age or older and some disabled persons. The program has two parts. Part A, hospital insurance, covers inpatient hospital, skilled nursing facility, hospice, and home health care. Part B, supplementary medical insurance, covers many types of noninstitutional services, such as physicians, clinical laboratory, X-ray, and physical therapy services. Both parts require beneficiaries to share in the cost of their care through deductibles and coinsurance.

Almost from Medicare's beginning in 1966, private insurance companies have offered Medigap policies to cover some of the out-of-pocket costs incurred by Medicare beneficiaries. Because of abuses identified in marketing Medigap policies, the congress in 1980 added a section, commonly known as the Baucus amendment, to the Medicare law. This section set forth requirements that must be met before a policy can be marketed as Medigap insurance. The Baucus amendment incorporated by reference the model Medigap regulations adopted in June 1979 by the National Association of Insurance Commissions (NAIC) The model:

—required Medigap policies to cover Medicare's inpatient hospital and part B coinsurance and prohibited the policies from limiting their liability below certain levels;
—standardized many terms used in policies;
—mandated that policy termination and cancellation clauses be prominently displayed;
—limited the period during which payment can be denied for preexisting conditions; and
—required that purchasers have a "free look" period during which they can cancel the policy and receive a full refund of any payments made.

In addition to setting the NAIC model regulations as federal Medigap standards, the Baucus amendment established loss ratio targets for policies. Medigap policies had to be expected to pay out at least 60 percent of premiums as benefits for individual policies and 75 percent for group policies. The amendment also established federal criminal penalties for engaging in abusive marketing practices for Medigap policies.

The Baucus amendment retained the traditional role of the states as the regulators of insurance, as long as they have regulatory schemes at least as stringent as the federal requirements. The amendment also established the Supplemental Health Insurance Panel, which reviews state regulatory programs and approves those that meet the federal Medigap requirements. In those states whose programs have not been approved by the Panel, insurance companies can seek federal certification of Medigap policies directly from the Department of Health and Human Services.

Our 1986 report on Medigap insurance concluded that the Baucus amendment had accomplished its primary goal of increasing and standardizing state regulation of Medigap policies [1]. At that time, 46 states and the District of Columbia had been approved as meeting federal requirements. This, in turn, had increased the protection afforded the elderly against substandard and overpriced policies.

Under the NAIC standards, Medigap policies were not intended to provide full catastrophic insurance coverage for acute or long-term care. The policies did not limit a policyholders' out-of-pocket expenses. For example, under the standards in effect before January 1, 1989, Medigap policies were required to cover 90 percent of covered charges for hospital stays longer than 150 days (the maximum period of Medicare coverage) up to a lifetime total of 365 days of inpatient care. Also, Medigap policies were allowed to limit benefits under the policy to $5,000 for part B type services. In addition to the above limits on benefits paid, Medigap insurers can choose not to insure certain individuals, while Medicare's new catastrophic coverage, discussed below, applies to all Medicare beneficiaries.

HOW THE CATASTROPHIC COVERAGE ACT CHANGED MEDICARE

The Medicare Catastrophic Coverage Act (P.L. 100-360), which became law in July 1988, provided the most significant expansion of Medicare benefits since the program's beginning. Beneficiary out-of-pocket costs for covered services will be capped, and additional services will be covered when the law is fully implemented.

The provisions of the Catastrophic Act related to part A of Medicare, which covers inpatient hospital services, generally became effective on January 1, 1989. The principal changes to part A were:

—The maximum beneficiary liability for covered inpatient hospital services in a year will be one inpatient hospital deductible, set at $560 in 1989. All inpatient coinsurance requirements were repealed, as was the limit on days of care during a benefit period. While only a small percentage of beneficiaries have very long hospital stays, this change gives them a substantial benefit. For example, under the old law, a beneficiary hospitalized for 150 days (the maximum possible coverage period), would have been liable for the $560 deductible and $21,000 in coinsurance. Under the Catastrophic Act, the beneficiary's liability is limited to $560. An additional benefit is the limit of one hospital deductible per year; previously beneficiaries could be responsible for more than one deductible in a year if they had multiple hospitalizations.
—The number of days of care covered for skilled nursing facility care increased from 100 to 150 and the method of computing coinsurance changed. Under prior law, the first 20 days of care were without cost to the beneficiary, while during

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[1] *Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Polices* (GAO/HRD-87-8, Oct. 17, 1986).

the next 80 days the beneficiary was liable for coinsurance equal to one-eighth of the hospital deductible each day, which would have been $70 per day in 1989. Now, beneficiaries are responsible for coinsurance for each of the first 8 days of care, and the coinsurance is equal to 20 percent of the national average cost of a day in a skilled nursing facility, $25.50 in 1989. Again, relatively few beneficiaries have long stays in skilled nursing facilities that qualify for Medicare payment, but those that do will benefit substantially under the Catastrophic Act. For example, a beneficiary with a 100-day covered stay would have been liable for $5,600 in coinsurance under prior law but is now liable for $204.

—The hospice care benefit was extended from a maximum of 210 days to an indefinite period. Also, the coverage requirement for home health services when patients need extensive care was specified, with the effect that more intensive home care is now covered.

The Department of Health and Human Services (HHS) estimated that the actuarial value of these changes to part A is $65 per beneficiary in 1989.

Most of the changes to part B, covering physician and related services, will take effect on January 1, 1990, and will be fully in place by 1993. Major changes are:

—Beneficiary liability for the part B deductible and coinsurance will be limited to $1,370 in 1990, whereas there was no limit under prior law. The limit will be adjusted each year to an estimated amount so that 7 percent of beneficiaries will meet it.

—New benefits for respite care to relieve the person who normally assists a Medicare beneficiary with essential daily personal care and for periodic mammography screening will become effective in January 1990.

—Beginning on January 1, 1991, Medicare will for the first time help beneficiaries pay for insulin and outpatient prescription drugs that can be self-administered.[2] After meeting a deductible, set at $600 for 1991 and $652 for 1992, Medicare will pay a portion of beneficiaries' drug costs. Medicare will pay half the cost in 1991, 60 percent in 1992, and 80 percent in 1993. The deductible for 1993 and following years is to be set so that 16.8 percent of beneficiaries will meet it.

In summary, these changes, when fully implemented in 1993, will significantly expand Medicare benefits well beyond those previously available through both the program and most Medigap policies. The new provisions include unlimited hospitalization for approved care, subject only to a single annual deductible. The skilled nursing and home health benefits were both expanded. Beginning in 1990, Medicare will also cap a beneficiary's out-of-pocket share of approved charges for services covered by part B. New benefits for respite care, mammography screening, insulin, and outpatient prescription drugs further improve the protection offered by the program.

HOW THE CATASTROPHIC COVERAGE ACT AFFECTS MEDIGAP POLICIES

Before the Catastrophic Coverage Act, Medigap policies were required to cover part A inpatient hospital coinsurance, but now the need for such coinsurance coverage has been eliminated. Also, the coinsurance for skilled nursing facility care was limited to a relatively low amount, $204 in 1989. Under the former standards, Medigap policies were not required to cover this coinsurance, but a number of policies did. In addition, Medigap policies had to cover 90 percent of the costs of hospital care for up to 365 days after a beneficiary had exhausted the maximum Medicare benefit of 150 days in a spell of illness. The need for this coverage was also eliminated because Medicare now covers 365 days of care per year. Thus, in 1989 there is no required coverage for Medigap policies related to part A services. Although not required to, many Medigap policies cover the inpatient hospital deductible. For these policies, the maximum exposure for 1989 is $560, and for such policies that also cover skilled nursing facility coinsurance, the maximum exposure is $764.

As far as part B benefits are concerned, under the former standards, Medigap policies were required to cover the 20-percent coinsurance, and insurers were not permitted to restrict the policy's coverage to less than $5,000. By way of comparison, in 1990, a Medicare beneficiaries' liability for part B coinsurance will be capped at $1,295, which must be covered by a Medigap policy. For those Medigap policies that also cover the part B deductible, their exposure in 1990 will be $1,370.[3]

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[2] On January 1, 1990, coverage of intravenous drugs that can be safely administered in the home will be covered under the drug benefit.

[3] Medicare counts beneficiary liability for catastrophic coverage purposes as the difference between the Medicare-allowed amount for a service and the Medicare payment. If a provider

Continued

In our 1986 report we also discussed the kinds of services Medigap policies covered that Medicare did not. Very few policies provided any such coverage.

In summary, the Catastrophic Coverage Act substantially reduced the maximum exposure to benefit parents of Medigap policies. In 1990, Medigap policies will be required to cover only the out-of-pocket limit for part B services; without the act policies would have been required to cover an amount in the neighborhood of $50,000.

LOSS RATIOS OF MEDIGAP POLICIES

In our 1986 report, we discussed the loss ratios of 398 Medigap policies, which together accounted for about $2 billion of an estimated nationwide total of about $5 billion in 1984 premiums for such policies.

A loss ratio represents the percentage of premiums collected that are paid in benefits; thus, it is sometimes considered a measure of the policy's economic value. The actual loss ratios of most policies discussed in our 1986 report were below the Baucus amendment targets of at least 60 percent for individual policies and 75 percent for group policies. The loss ratios of the policies offered by most of the nine Blue Cross/Blue Shield plans reviewed and by the Prudential Life Insurance Company—the policies most commonly purchased—were above the targets. The Blue Cross/Blue Shield individual policies we reviewed had 1984 premiums of $776.6 million and a weighted average loss ratio of 81 percent; the commercial individual policies included in our analysis had nationwide 1984 premiums of $1.3 billion and an average loss ratio of 60 percent, and prudential—with a 1984 loss ratio of about 78 percent—had almost 25 percent of that business.

In preparing for hearings earlier this year [4] and for additional work we are doing concerning Medigap insurance, we obtained 1987 loss ratio information, the latest available, on 92 commercial policies, 75 Blue Cross/Blue Shield individual plans, and 47 Blue Cross/Blue Shield group plans, which had a total of about $4.9 billion in premiums in 1987. The 1987 loss ratios for the commercial policies averaged 74 percent. Prudential's share of total premiums has increased significantly since 1984, and although many policy loss ratios increased between 1984 and 1987, Prudential's relatively high loss ratio of 83 percent in 1987 helped raise the overall average loss ratio for the commercial policies. Without Prudential, the other commercial policies' loss ratios averaged about 59 percent. Total premiums for the commercial policies were over $1.7 billion. The 75 individual Blue Cross/Blue Shield plans had total 1987 earned premiums of $2.6 billion and an average loss ratio of 93 percent. Those same Blue Cross/Blue Shield plans reported loss ratio data for 47 group plans. For these plans, earned premiums totaled $600 million and loss ratios averaged 96 percent.

For the 92 commercial policies, a loss ratio of 74 percent means that for each $1 of premium, 74 cents was returned as claims payments or used to increase reserves, and 26 cents represented administrative and marketing costs and profits. For the Blue Cross/Blue Shield plans, the comparable figures are 93 cents in benefits and 7 cents in costs and profits for individual plans and 96 cents in benefits and 4 cents in costs and profits for group plans. In 1987, for each $1 Medicare spent, about 98 cents was for health care services and about 2 cents for program operational expenses.

Mr. Chairman, this concludes my prepared remarks. I will be happy to answer any questions you have.

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charges more than the allowed amount and does not accept assignment, the beneficiary is also liable for the amount by which the provider's charge exceeds the Medicare allowance. In our 1986 report, we identified only a few Medigap policies that helped pay this additional beneficiary liability.

[4] "Medigap Insurance: Effects of the Catastrophic Coverage Act of 1988 on Benefits and Premiums", Statement of Mr. Michael Zimmerman before the Subcommittee on Commerce, Consumer Protection, and Competitiveness, House Committee on Energy and Commerce (GAO/T-HRD-89-13, Apr. 6, 1989).

COMMUNICATIONS

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

On behalf of the American Federation of Government Employees, AFL-CIO (AFGE), and the more than 700,000 government employees whom we represent, I am pleased to submit this statement on the perceived problems with the Medicare Catastrophic Coverage Act of 1988. AFGE supported the enactment of this legislation last year, and continues to support it as an important first step in the Federal Government's fulfillment of its health care responsibility to America's elderly population, as established by the Medicare program in 1965.

In recent months, three aspects of the Catastrophic Coverage Act have come under criticism: the financing mechanism, the duplication of benefits, and the inadequacy of the coverage. In this testimony, I shall limit my comments to the first two issues, as they directly affect Federal retirees.

THE FINANCING MECHANISM

The Catastrophic Coverage Act is currently to be financed through a combination of two sources. The first is a $4 per month increase in existing Medicare premiums. This additional $48 per year is to be paid by all 33 million Medicare recipients. The second source of financing is the controversial surcharge which is based on the taxable income of Medicare eligible citizens. The surcharge is a progressive income tax which will only be paid by the two-fifths of Medicare beneficiaries with the highest federal income tax liability. The rate in 1990 is $22.50 for each $150 of taxes owed, with a maximum annual liability of $800 for an individual.

Some opponents of the surtax claim that it is too high because the surplus revenues it will generate over five years are too high. When the law was passed, the financing was designed so that all benefits could be paid, and a $4.2 billion reserve could be accumulated through fiscal years 1989 to 1993. If the estimates of the five-year surplus, which range from $6.2 billion according to the Treasury Department, and up to $10 billion according to the Congressional Budget Office (CBO), are valid, then some reduction in the rates is certainly warranted on these grounds.

Opposition to the surtax has also been voiced by various groups who claim that insofar as the Catastrophic Care Act constitutes a form of social insurance, the tax should be levied on a broader base. Currently, only the elderly are forced to pay for this benefit, rendering it a type of "age tax," according to these critics. The essence of the argument is that all of society benefits by having some of the extraordinary, or "catastrophic" costs of the health care of the elderly insured. Thus, at least some taxpayers of all ages should be asked to pay for this important social need.

In support of this view, Senators Levin, Harkin, and Representative Bonior have proposed repealing the surtax on the richest 40 percent of Medicare beneficiaries. In its place would be an increase in the marginal income tax rate, from 28 percent to 33 percent, on couples with incomes in excess of $208,510 (or $109,050 for individuals). The revenue thus generated would relieve the approximately 13 million highest income Medicare beneficiaries from the surtax, and raise the same amount of money from the 600,000 highest income Americans of all ages.

AFGE wholeheartedly endorses the intent of this type of bill. We firmly believe that social needs should be met through progressive corporate and personal income taxes. However, we have serious reservations about essentially "dedicated" revenues in the context of the current budget difficulties. If the budget deficit were not as large and politically problematic as it is, if federal employees were receiving pay raises sufficient to bring their salaries into line with their private sector counterparts, and if agencies were sufficiently funded so that they had the resources to carry out their missions properly, then funding the Catastrophic Care Act out of general revenues would make good sense. As it is, the demands on general revenues which would compete with the Catastrophic Care provisions render the current separation a wise policy.

Other alternatives to the current progressive surtax which have been mentioned include flat taxes and increases in the FICA. AFGE opposes these types of alternative financing mechanisms because they are regressive and, therefore, constitute a tax policy which is inferior to the mechanism now in existence.

DUPLICATION OF BENEFITS

The Catastrophic Coverage Act includes a provision for maintenance-of-effort to protect the interests of beneficiaries who are covered by employer-paid health insurance, if the employer pays at least 50 percent of the cost of the premiums. This provision was designed to avoid having beneficiaries pay twice for the same benefits. The law gives employers who offered insurance benefits to their retirees similar to those in the new law two choices. To compensate the beneficiaries of the Catastrophic Coverage Act, they may introduce additional benefits of equivalent actuarial value to those now covered by the Act, or they can choose to provide a refund equal to the actuarial value of the new benefits. It is in this area that federal retirees have faced problems.

Several health plans in the Federal Employees Health Benefits Program (FEHBP) offer benefits which duplicate those provided in the Catastrophic Care Act. In 1987, when AFGE first testified on Catastrophic Care Insurance, we pointed out the need for OPM to require the establishment of a Medicare supplemental option (a "medigap" plan) to serve the needs of Medicare-eligible federal annuitants. Today, AFGE is still trying to effect the establishment of a Medicare supplemental plan within FEHBP, as part of our efforts to attain overall reform of the FEHBP.

In the meantime, the,maintenance-of-effort provisions of the Act do apply to the federal government in its capacity as employer. The Health Care Financing Administration (HFCA) has determined that the 1989 national actuarial value of the Medicare Part A benefit improvements is $65. The national average actuarial value of the Part B benefits, which go into effect in 1990, will be published by the HCFA sometime prior to January 1, 1990. Preliminary estimates indicate that it will be approximately $160. Employers are free to use this figure, or to determine the actuarial value in each geographical area in order to comply with the maintenance-of-effort provisions. In 1989, however, the federal government refunded only $3.10 per month to Medicare eligible annuitants throughout the country, without providing any additional health insurance benefits. This $37.20 per year constitutes only 57 percent of the $65 national average actuarial value of the duplicated benefits. In some areas of the country, this may have been adequate compensation, but there are other areas of the country where health insurance costs are much higher than the average. The bulk of Medicare-eligible federal retirees live in these high cost areas. Enrollees in these areas deserve a higher refund. The rebate to federal retirees who are eligible for Medicare is clearly inadequate, and should be increased, retroactively, to cover the entire value of the Catastrophic benefits.

CONFUSION OVER FINANCING AND DUPLICATION OF BENEFITS

As mentioned above, there is much confusion over how the financing mechanism works. The new Catastrophic law added $4 to the basic flat monthly premium for beneficiaries enrolled under Part B (physician care), as well as a supplemental premium on Medicare beneficiaries with incomes high enough to be subject to federal income tax. The amount of the supplemental premium, or surtax, was never meant to be equivalent to the actuarial value of the Catastrophic benefits to an individual taxpayer. The supplemental premiums are based on ability-to-pay, thus the well-off subsidize the less-well-off. This constitutes social insurance, the cross subsidy of the wealthy to the poor and lower-middle class. Those who oppose the supplemental premium structure on the grounds that it violates social insurance principles are, therefore, mistaken. Both costs and benefits are socialized, with most of the costs borne by those with the ability to do so, based on income. The confusion arises from misconstruing the supplemental premium as the price of one's own insurance coverage, instead of a social insurance tax.

For federal retirees, the only fair way to assure maintenance-of-effort, and thereby avoid the problem of being forced to pay twice for the same benefit, is to require the establishment of a Medicare supplemental policy in FEHB, within the context of overall reform of FEHB to bring the system in line with the plans offered by the private sector. The duplication of payments and benefits should not be measured against the sum of the supplemental premium and the increased Part B premium, but rather against the actual FEHBP premium, and the HFCA estimate of the value of the catastrophic coverage.

CONCLUSION

AFGE continues to support the Medicare Catastrophic Coverage Act as an important first step in our government's meeting its responsibilities for adequate health care for the elderly. There are currently problems with enforcement of important provisions of the act, such as maintenance-of-effort by employers. The financing mechanism could also be improved as part of an overall reform of federal tax policy: progressive corporate and personal income taxes should be increased so that the government can spend more rationally and generously on a wide range of social needs, especially including comprehensive health care insurance for all citizens, not just the elderly.

I thank you for this opportunity to voice AFGE's concerns and opinions pertaining to the Medicare Catastrophic Coverage Act of 1988. If the Chairman or any Member of the Committee has any questions, I will be happy to respond.

AMERICAN POSTAL WORKERS UNION, AFL-CIO

Mr. Chairman, and members of the Committee: My name is Moe Biller. I am President of the American Postal Workers Union (APWU), AFL-CIO and its Health Plan. APWU is the collective bargaining representative of 335,000 active and retired employees of the United States Postal Service. The APWU Health Plan, with over 250,000 participants, is one of the largest employee organization sponsored plans in the Federal Employees Health Benefits Program.

A major portion of the APWU Health Plan enrollees are Medicare-eligible retirees, who were impacted by the enactment of the Medicare Catastrophic Protection Act of 1988, Public Law 100-360. It is on behalf of these retirees that I wish to express my appreciation to the Committee for the opportunity to comment on the effect of the catastrophic protection law on postal retirees.

During the 100th Congress, as the Medicare debate focused on the feasibility of providing expanded benefits to Medicare participants and the appropriate method of financing those benefits, APWU raised several issues of concern about the effect of the proposed legislation on our retired members. We questioned both the proposed financing mechanism and the duplication of catastrophic benefits for postal and federal retirees which would result from enactment of the law.

The first issue was partially addressed when the Senate adopted an amendment, proposed by our union, which equalized the tax treatment between public sector pensions and Social Security benefits. Without this amendment, authored by Senators David Pryor (AR) and Pete Domenici (NM), postal and federal retirees, whose pensions are fully taxable, would have been liable for far greater supplemental premiums than Social Security beneficiaries, a portion of whose benefits are tax-exempt.

Although the House-passed bill did not address the tax treatment differential, the House-Senate conference committee included the Senate-approved Pryor-Domenici amendment in the final version of the Medicare Catastrophic Protection legislation, which was signed into law on July 1, 1988.

Nevertheless, although the supplemental premium calculation formula was equalized, we remained firm in our belief that the benefits proposed by the legislation were excessive in their costs. Our concern over the cost of the catastrophic coverage has been validated by recent studies.

The Medicare Catastrophic Protection Act instituted an increase in the basic Medicare monthly premium and made Medicare beneficiaries liable for a newly-created supplemental premium—a surtax—to pay for the catastrophic benefits. The surtax is based on an individual's or couple's federal income tax liability. For every $150.00 of federal income tax liability, Medicare participants would be required to pay an additional $22.50 (15 percent) for the catastrophic insurance benefits, up to a maximum of $800.00 for individuals and $1600 for couples in 1989. The surtax is scheduled to increase each year through 1993, when it reaches a maximum level of $42.00 for each $150.00 of federal tax liability.

Under this formula, an individual or couple with $3000.00 in federal income liability will be assessed a supplemental premium of $450.00 in 1989, while a single individual with a tax liability of only $5300.00 will be assessed the maximum supplemental premium of $800.00. In testimony before this Committee by the Joint Committee on Taxation, it was estimated that 1.8 million Medicare recipients will be liable for the maximum supplemental premium this year. Many of those who will be assessed the supplemental premium will, in our view, be postal and federal retirees.

Under current, unrelated law, postal and federal workers are authorized to retain the health insurance coverage they carried as active workers when they retire, if certain conditions are met. The health benefits programs in which postal and federal workers participate, operate under the auspices of the Federal Employees Health Benefits Program (FEHBP), and these plans are required to provide retired participants with protection against catastrophic illness. Postal and federal enrollees pay for this coverage through their health insurance premiums. This was the second issue of concern which we raised when Congress debated this legislation in the last Congress.

In 1983, as part of the Social Security Act Amendments, Congress mandated that all current postal and federal workers be liable for the Medicare Hospital Insurance (HI) tax, and in anticipation of a new retirement system for postal and federal workers, that all post-1984 hires in the Postal Service and executive branch agencies be fully covered under the Social Security system. However, no provisions were made, in the wake of either of these Congressional initiatives, to provide for the orderly coordination of health insurance coverage.

As a result, when Congress enacted the Catastrophic Protection Act, it duplicated coverage already provided to postal and federal retirees through the Federal Employees Health Benefits Program. When our health plan analyzed and compared the benefits provided under the catastrophic law with the benefits currently provided to our Medicare-eligible health plan enrollees, 'we found that there were few, if any, instances where the new law offers superior benefits.

In response to the issues which we, and others raised about the duplication of benefits during the catastrophic debate, the Office of Personnel Management (OPM) was directed to study the feasibility of developing a Medigap alternative for postal and federal enrollees in the Federal Employees Health Benefits Program.

In the interim, the catastrophic protection law mandated that FEHB premiums were to be reduced for Medicare-eligible participants. The reduction was to be based in the actuarial value of the benefits offered in the new catastrophic insurance law.

In July of last year, the Office of Personnel Management estimated the value of the new Medicare catastrophic benefits to be $3.10 per month for each covered Medicare-eligible retiree, or $37.00 per year. A reduction of that size does not equitably compensate postal and federal retirees for the vastly increased tax liability which they will incur as a result of the new catastrophic insurance law. Further, to date, the Office of Personnel Management has made little significant progress toward the establishment of a coordinated Medigap program for Medicare-eligible postal and federal retirees.

As a result, Medicare-eligible retirees who are enrolled in the American Postal Workers Union Health Benefits plan are facing difficult choices which will not be mitigated unless Congress acts to revise the financing mechanism of the Catastrophic Protection Act. Either Medicare-eligible postal and federal retirees must bear the burden of paying both their FEHB health insurance premiums and the supplemental premium or they may be forced to abandon their union-sponsored health insurance program for a government sponsored program with inferior benefits. If the retiree elects to drop his or her union-sponsored insurance, that decision can never be reversed. We believe that these choices are untenable for postal and federal retirees.

In the interest of mitigating the adverse effects of the supplemental premium, the American Postal Workers Union urges your favorable consideration of S. 335, proposed by Senator John McCain (AZ), and its companion bill, H.R. 1564, sponsored by Representative Peter DeFazio (OR), in the House. These identical bills would effect a one year delay in the effective date of the supplemental premium and the additional benefits authorized under part B of the Medicare program, with the exception of the spousal impoverishment provisions.

We believe that a one year delay in the implementation of the supplemental premium will give the Office of Personnel Management sufficient time to craft an equitable Medigap proposal for postal and federal retirees. However, this would still leave the larger issue—that of funding—to be addressed.

In our view, that crucial problem can be best addressed by the adoption of the legislation (S. 1125, H.R. 2547) which was jointly introduced on June 6, 1989 by Senators Tom Harkin (IA) and Carl Levin (MI), and Representative David Bonior (MI) in the House.

We believe that the financing mechanism for the catastrophic insurance benefits is flawed and that merely tinkering with the surtax rates, threshold or cap, will not resolve the fundamental inequity on which the funding is based. That assumption—that Medicare enrollees must bear the full burden of the cost of the catastrophic benefits—is counter to the very precedent on which the Social Security system was founded.

The Harkin-Levin-Bonior legislation would provide the "midcourse correction" necessary to restore the financing equity to the Medicare system on which it was founded. While maintaining catastrophic protection for those in our society who need it, the legislation repeals the income-related supplemental premium and replaces it with the general funds realized through extending the existing 33 percent marginal tax rate to the wealthiest one percent of federal tax payers.

This nation faces many competing interests for its limited financial resources. Yet, as a nation, we have accepted the responsibility of providing benefits for those of our citizens—who cannot provide for themselves. The present financing mechanism of the Catastrophic Protection Act abrogates this responsibility. The Harkin-Levin-Bonior proposal restores equity to the Medicare system and is sound public policy, consistent with that on which Social Security was founded.

We urge the Committee's favorable consideration of both of these proposals.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Sir: I am not yet eligible for Medicare but in anticipating the future, I am writing to protest the method of financing the present catastrophic insurance.

(1) It means an increased income tax for seniors above the national income tax ceiling.

(2) It does not cover long-term convalescent care which is where the primary need is and the usual cause of senior impoverishment.

(3) One does not have the choice of not enrolling in Medicare and avoiding this discriminatory tax by taking private insurance since an individual is taxed at age 65 whether or not he enrolls in Medicare,

I feel that since as a senior with no children in the educational system, part of my taxes support public schools, then in turn those young enough to have children in the school system should kick in to finance Medicare—a quid pro quo arrangement if you will.

The above paragraph is only one example of how the practice of financing a project is spread over the general Population. I need only give one example to make my point even though there are others.

I'm making my feeling known to you because I understand you are holding hearings on this matter, Thank you.

Yours truly,

ESTHER ARDARY.

STATEMENT OF ARNOLD J. AUERBACH, PHD, PROFESSOR EMERITUS OF SOCIAL WORK, SOUTHERN ILLINOIS UNIVERSITY AT CARBONDALE

Unable to appear before the hearing on June 1 regarding the Medicare Catastrophic Coverage Act of 1988, I respectfully request that the following statement be presented for the consideration of the members of the hearing committee.

The inequities of the Act have been so forcefully and repeatedly presented that I should like to suggest positive steps to remedy the faults and, without further expense to the government, extend real benefits for long term care.

Admittedly, the Catastrophic Act should be revised but that situation presents us with an opportunity to meet the real health needs of the elderly population: the revisions of the Act should eliminate the expensive drug provision and the income tax "supplementary premium."

A Medicare Part C addition should be acted to extend benefit for long term care in the home or in an institution-SNF, INF or custodial based on ADL certification by a responsible agency.

Like Medicare Part B, Part C for long term care should be optional with premiums deducted from Social Security pensions, such premiums placed in a trust fund for long term care. The cost of the premium should be the same as Part B ($31/month this year) and parallel the increases each year.

Benefits should be based on the amount collected from Part C premiums that reside in the LTC trust fund. On the basis of estimates from private insurance companies that cover LTC insurance, beneficiaries may receive $1,200 per month for nursing home care, $600 for home care. (Medicare does not have the promotional and administrative expense of private insurance companies). Admittedly, the $1,200 monthly benefit would not pay all nursing home costs (Part B doesn't pay all medical costs, either) but the nursing home resident still gets an average $600 a month Social Security pension and may be able to supplement the difference from savings income. Payment should be made directly to the insured, not the nursing home operator.

The Secretary of Health and Human Services should review each year tax available funds in the LTC trust fund to determine the monthly allowance for home health or nursing home care. No Federal subsidy should be made; thus long term care will be fully covered by the elderly population, but it would be voluntary. Poor elderly may opt not to enroll and Medicaid would be available for them.

The Medicare Part C option should also result in reduction of Medicaid which pays more than 50 percent of nursing home fees. The savings may be used to increase per capita Medicaid payments for those homes that offer high quality services.

During the past year, I have presented this idea to dozens of senior organizations and individuals that I have addressed in my capacity as SIU Emeritus College director, a director of the Illinois Association of Senior Citizens and an Area Agency on Aging, and as Research Fellow of the Gerontological Society of America studying the long term health care needs of the elderly. I have found almost unanimous approval of elderly in the Medicare Part C addition as outlined above.

I realize that this suggestion is sketchy and leaves some gaps, especially about those persons now who are over age 65 and need care. But my proposal is for those who will be 65, a long term proposal, with accommodation to be made for the current crop of oldsters who need such care.

I submit this proposal for your consideration and include a short article from Contemporary Long Term Care, the trade journal of the nursing home industry.

I am aware there are other good proposals for revision of the Catastrophic Act but I see the current situation as presenting an opportunity for going beyond the patching up of a faulty measure an opportunity to meet real needs for long term care, controlling health costs, and improving the quality of nursing home care—all without additional Federal funds and with the enthusiastic approval of the elderly citizens themselves.

Enclosure.

VIEWPOINT

Filling the Gap in Long-term Care Financing

Addition of Medicare Part C seen as step toward better health insurance plan for nation's elderly.

by Arnold J. Auerbach

The growing concern about the need for long-term care insurance for the elderly is justified by the vital statistics showing explosive growth in the over-80 population and the "side effects" this development is causing in the increasing need for institutionalizing those who cannot remain in their own homes.

The absence of any viable LTC insurance plan has strained Medicaid funds, the government medical assistance plan for the indigent. At the same time, millions of middle-income elderly have gone broke paying nursing home fees that average in excess of $1,800 a month. And the problem is getting worse.

Planning Considerations. Many suggestions have been put forth — from private insurance to Medicaid — but most seem to ignore some basic principles that should be considered in any plan.

- Most elderly are not poor. And those who can afford long-term care insurance do not want the government to pay for any part of it.
- Most elderly in the middle-income bracket do not need to have their entire nursing home bill covered by insurance benefits. In a nursing home they still get their Social Security pensions (which average about $700 monthly), and some savings income or family help can make up the difference.
- The elderly on Social Security pensions object to paying high premiums to private insurance companies, much of which goes for television advertising, junk mail, payments to elderly actors, executive salaries and profits to company stockholders.
- The easiest, most economical and plan-proven system of health insurance is Medicare: Part A (hospital) and Part B (medical) have worked for 22 years. Both are, however, for acute problems.

The Proposal. A Part C for chronic (long-term) health conditions should be established under Medicare to cover institutional care. Like Part B, it could be optional (more than 80 percent have opted), deducted from the monthly pension check ($24.80) and substantially covered by the annual COLA. It would be a one-time commitment, and most pensioners would be reminded only once a year that it's being deducted monthly and going up every year.

At current premiums, the benefits should pay more than half the average nursing home cost. That would save the taxpayers more than $8 billion annually in nursing home Medicaid costs by keeping middle-income elderly solvent. Poor elderly could still get their Medicaid support. But that should reduce public assistance in nursing homes by a third; from 66 to 33 percent. As Part C (and B) premiums increase, the benefits also would increase. With no sales, administration or profit costs, Part C income, which would be restricted to cover long-term care expenses, should be able to cover larger portions of nursing home increases.

Medicaid's Role. What is being ignored in all of the long-term suggestions is how an insurance plan could help improve the quality of care in the nursing homes which is generally poor. Typically legislators think that it can be done by passing laws that wield a big stick. Most nursing home operators are not ogres preying on the helpless elderly.

Dependent on Medicaid for the majority of patients, institutions are strapped by too-low allowances by states that make it impossible for them to hire trained help, competent professionals and install attractive accommodations for quality care. Most have to overcharge private-paying residents to make up Medicaid's shortfalls.

The savings in Medicaid could be used to adopt a "carrot," as well as a "stick." States could increase Medicaid allowances to those nursing homes that comply or exceed minimum standards — a system of ratings that rewards better quality of care at no additional cost to the taxpayer.

Conclusion. The addition of a Part C for long-term health care for the elderly would complete the Medicare package, filling the gap created in 1965 when long-term illness was not considered a widespread problem. This addition should make it easier for the elderly to pay premiums, keep costs low, cost the taxpayer nothing, improve the quality of care and keep the dignity and independence of middle-income elderly intact by keeping them off the medical welfare rolls.

Why hasn't this plan received more attention from legislators? Because most of them depend on 24-year-old staff members to feed them statistics and ideas. And although the staffers are hard working and bright, they often fall into the stereotypical stance of regarding the elderly as either antagonists or helpless, indigent invalids. Neither view is justified.

Medicare Part C would not, of course, solve the financing problems of health care in our nation, but it is a needed measure to cover the gap in our present system. With it in place, we may be able to move toward a more comprehensive health insurance plan for all our citizens. **CLTC**

Arnold J. Auerbach, Ph.D., is director and professor emeritus of the Emeritus College of Southern Illinois University at Carbondale. He has been involved in social and community activities for the elderly for over 50 years.

N'EMPORARY LTC JULY 1988

Senator LLOYD BENTSEN, *Chairman,*
Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen: I am writing on behalf of my wife and myself to voice our strong objection to the Medicare Catastrophic Act of 1988.

We are both senior citizens and I have retired from California State employment.

My income is from the California State Retirement System and I am not eligible for social security or Medicare.

It is not the American way to tax a small segment of the people, most of whom are on limited or fixed income, for medical insurance usable by only an even smaller segment of the same People.

As a comparison the whole tax paying population pays school tax whether they use it or not. This is an equitable tax situation.

We strongly object to the passage and enactment of this unusually biased Catastrophic Act and request it be reformulated.

Respectfully,

SADEK M. AYOUB.

LAURA WILSON, *Hearing Administrator,*
Senate Dirksen Office Building,
Washington, DC.

Subject: Medicare Catastrophic Coverage Act of 1988

I am a retiree from the State of California. As such I have earned a supplement to Medicare Policy through my years of working for the State. It includes most of the same items that will be covered by the Medicare Catastrophic Act. It seems grossly unfair that I am now forced to pay for added insurance for which I already have coverage for myself and my wife.

I have always worked hard and tried to save enough money so I would never be a burden to anyone in my old age and also have enough money to enjoy a few of the nicer things in life during my retirement. This dream is getting farther and farther from my grasp due to this new Medicare Act.

In 1989 my top tax bracket will amount to (Federal 28%, Medicare 15%, State 6%.)

In 1990 my top tax bracket will jump to (Federal 28%, Medicare 25%, State 6%.)

In 1993 my top tax bracket will jump to (Federal 28%, Medicare 28%, State 6%.)

These figures assume that there will not be a raise in Federal or State Income Tax percentages during this period. A very unlikely possibility.

This whole scheme of things seems very unfair to elderly retirees.

I never objected to paying for Social Security and Medicare while I was employed and I think the Catastrophic Coverage should be paid for the same way, while a person is working and earning money, not after he is no longer capable of earning a living.

It seems a shame that a retiree has to dip into his savings every year in order to try to maintain a decent standard of living that he has worked so hard to establish through years of work, saving and trying to manage well. It appears that the person who lived it up to the hilt and spent all their money as they went along are really the people who are benefiting from this Act and the rest of us elderly are paying for it. It is a real slap in the face for those who tried to do it right.

Anything you can do to right this wrong will certainly be appreciated.

Respectfully,

WALKER L. & VIRGINIA C. AYRES.

Hon. PRESIDENT GEORGE BUSH,
The White House,
Washington, DC.

Dear Mr. President: I'm writing you this letter in hopes of changing your mind in regards to several issues and to let you know what I perceive the people in my area are thinking in regards to some of your policies as well as the government as a whole.

No. 1—In general, people are talking openly of their disillusionment with government policies. Almost everyone knows that socialist programs haven't worked; it has brought about inflation and corruption as the government almost desperately makes effort to maintain control of the economy. There is wide spread questioning about the leadership and legitimacy of both the Republican and Democratic party and this seems to be among all the economic classes with the possible exception of the welfare recipients. Most of us no longer regard our leaders as heroes whom we would follow without questioning their motives or wisdom. Sir, I'm a military retiree. I worked hard for years and will be retiring on Social Security next month and I would like to point out some of the things that has disillusioned me greatly with your policies and the direction the government is going. I voted for you in good faith and have always voted Republican during the national elections. I've always felt that great nations like great men should keep their-word. That I as an American when I say something, I mean it whether a treaty or an agreement or a vow made on marble steps. I will die trying to keep it.

Mr. President: No. 1—The budget which your administration has submitted to Congress contains recommendations to eliminate the COLAS for retired military for fiscal year 1990 and to reduce future adjustments by 1% under the CPI; this recommendation does not square with the philosophy of keeping ones word. As president of this great nation it's generally accepted that you speak for the American people and when America says something it's generally accepted that Americans mean it and here is what America has been saying to its fighting men and women to keep them in the service of their country.

Example: A 1983 career advisory pamphlet issued to service members contains the following statement' "The bottom line is that you cannot lose what you are already entitled to. . . . Retirement pay is increased by future increases in the Consumer Price Index."

Example: The House Armed Services Committee Print No. 3, Title 37, United States Code, March 1985, contains this statement: "The COLA . . . reflects the progressive effort made by both the Executive Branch and the Congress to develop an automatic mechanism which would, in the last analysis, guarantee every military member that the purchasing power to which he was entitled at the time of retirement would not, at any time in the future, be eroded by subsequent increases in consumer prices."

A similar statement was contained in the 1972 edition of the HASC print (92-38) January 18, 1972, page 7531 and in every subsequent edition. Military retired pay has already fallen more than 7 percent behind inflation since 1981. The action proposed by your budget Mr. President would almost double to 13 percent behind inflation by the time the next COLA would be paid on January 2, 1991. At a time when the services are struggling to retain talented people, what kind of message does this budget send to those who may be considering a military career?

Now lets get to the Social Security, although I was very young when Social Security was first initiated; I understood its principles that it was only a supplement to a persons general retirement, but it also was excluded from taxes, but Congress both Democrat and Republican in their haste to gain votes has watered down, added to and liberalized it so people who don't deserve it take away from people who do, i.e. your recent suggestion that Congress not rectify their mistake by repealing the selective taxation on elderly people to support the so-called Catastrophic Medical plan for a selective few of the elderly people who didn't make provisions for themselves in their earlier days.

Mr. President I as a layman could figure out a better and fairer tax system to support the Catastrophic Medical plan than Congress and the previous administration. If a tax had to be added, why not put it on a broader basis of the general populous i.e., the working person who stops paying into Social Security at $48,000 (this is the 1989 amount and changes every year). Why not make the cut-off point at $50,000. This should give you in Congress enough money to cover the plan rather than robbing the elderly alone with such a discriminatory tax.

I would further like to inform you Mr. President that my wife and I will not vote for anyone who supports this Catastrophic Medicare legislation in its present form and will do everything that we can in our area to persuade other people of voting age to do the same and it may well preclude you from becoming a 2-term president. I want you to know that we will be sending a copy of our letter to you to each one of our representatives in Congress and the Senate. In other words Mr. President, WE ARE MAD AS HELL about the Medicare Catastrophic Act of 1988.

Very truly yours,

J.C. Bailey, Retired USAF M/Sgt.

Hon. **Lloyd Bentsen**,
Chairman, Finance Committee,
Washington, DC.

Dear Hon. Senator Bentsen: I strongly disapprove of the CATCAP and its surtax. This law places the financial burden of increased medical benefits squarely on the shoulders of older Americans, though Americans young and old will receive coverage while 60% will pay only the surcharge and in some cases will get this paid for them. The 40% over age 65 will also pay for any and all people on disability and Medicare. Forty percent paying for all others. Is this fair?. It has been figured that those with a taxable income of $29,500 will pay the maximum. Is this fair? The people with lower incomes will pay nothing and the so-called wealthy will get a break because of the cut-off cap. Is this fair?

If only the recipients of this program are forced to pay for it, then why should I pay school taxes? I don't have children in school. My does my tax dollar pay for agricultural subsidies, let the farmer anti up for that. Social Security should and could pay for this program since everyone pays Social Security tax. Social Security is not a separate fund. The tax you pay is grouped with the rest of your tax and counted toward the National debt. All surplus is used like the other tax money.

Furthermore those of us who are in a military retired status whose income is derived primarily from hard earned pensions see that income being steadily eroded by programs imposed on us by Congress such as the imposition of this surtax. This is occurring at a time in our lives when expenses are being incurred for maintenance of items such as our aging homes and vehicles and puts a mental burden on us along with the question what's next?

When this bill was passed, our lawmakers must have been in a hurry to get home. The House voted 408-0 and the Senate voted 97-2. Could it be that only 2 people took the time to read what they voted on? Or is it that our representatives like the rest of our youth in the country can't read or those that do read, don't understand what they read.

Very truly yours,

J.C. Bailey, Retired USAF M/Sgt.

Senator **Lloyd Bentsen**,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen: We are senior citizens who have worked hard all of our lives and tried to save enough money so that we would not be a burden on society. Now, alone comes the Catastrophic Act of 1988, which is being forced upon us, without any choice on our part.

All of this talk about "wealthy senior citizens" is a real smokescreen. As near as we can figure, a taxable income of $8,000 makes us eligible to pay the full amount. Even in Washington, that would not make one a "rich" senior citizen.

This Act is not doing us any good at all, because we have a secondary insurance plan that pays for all the benefits they are talking about.

Everyone should know that elderly people are not kept in a hospital for any great length of time. They either die or are transferred to nursing homes.

We would appreciate any help you can give us on this matter.

Yours truly,

George and Neva Barker.

Senator **Lloyd Bentsen**,
Chairman, Senate Finance Committee,
Washington, DC.

Dear Senator: I am 84 years old and I have the State of California retirement insurance as a supplement to Medicare. I do not feel that the Medicare Catastrophic Insurance will benefit me in any way.

The method of payment for this Catastrophic Insurance would place a heavy burden on me as I am limited in my income.

I would appreciate anything you can do to rectify the injustice this insurance would be to me.

Sincerely,

Marie Bazlen.

Senator Lloyd Bentsen,
Chairman, Senate Finance Committee,
Dirksen Office Building,
Washington, DC.

Dear Senator: One of the more onerous pieces of legislation to have been enacted by Congress, acting in its own wisdom, and without sufficient and adequate public hearing adopted the Catastrophic Insurance Act.

In the first place, the Act is not even catastrophic, it doesn't take into consideration the problem of long-term care. Long term care becomes important when a person lives beyond insurance limitations. Yet there are some elderly who have provided that protection for themselves.

Second, the Catastrophic Act duplicates the insurance that I have already provided for myself and my wife, and have had for many years at the cost of over $120 per month.

I have written many letters to my senators, and congressmen requesting hearings to bring a discussion on problems raised by Congress, especially in the matter of equity and funding. There is stone walling against any action.

It is requested that the Congress reopen hearings; and that hearing be held in California in Los Angeles, San Francisco, and in Sacramento. A problem of this magnitude can not be settled equitably in Washington.

Further, Congress shall not banded the problem by tampering with the catastrophic tax, thinking this to be a solution. It shall be reconsidered and made equitable to all Seniors. It shall not attempt to displace present insurance that has been in place.

It was Thomas Paine who said: "A Government, even in its best state, is but a necessary evil; in its worst state, an intolerable one." There are many of us (Seniors) that will be watching what actions you tale to rectify this catastrophic fraud perpetrated on the Senior.

Burton G. Beamer.

Senator Lloyd Bentsen,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen: Please add our names to those protesting the Catastrophic surtax which applies to those individuals who are 65 years of age and over.

We feel this tax is very unfair, and strongly urge that action be taken to have it repealed.

Sincerely,

Roscoe M. and Betty J. Bell.

Senator Lloyd Bentsen,
Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Sir: Your attention is called herein to our vehement disturbance with the Medicare Catastrophic Act of 1988.

We believe it to be the most atrocious bit of hoodwinking and discrimination of we seniors that has ever been enacted by any government, let alone the United States government.

There aren't really enough of us able to get this message over to you people. Too many are incapacitated, too poor, or just haven't access to any means of communication to you to protest as they would want to.

The act is discriminatory to the elderly, unfair to begin with, and must be re-considered for financing. Get that clearly. Enclosed with this letter is a copy elicited from a local newspaper that spells out in lucid clarity just what is happening, and when the stench has reached all nostrils, there will be revolution the Chinese haven't even dreamed about!

Yours truly,

John P. and Rosemary E. Boyd.

Enclosure.

[From the Sacramento Union, June 15, 1989]

LISTEN TO LOW RUMBLING NOISE

BY MARCIE CROFOOT, GRASS VALLEY

Thank you for printing K.W. Lee's story on Capitol lobbying, the third party. Fortunately, it only skimmed the surface, since no one really wants to know the true depth of corruption.

Nice try, but I'm afraid it will take a few more decades of more and political decay before the stench invades every comer of our lives, finally forcing us to react.

Oh, a few of us are screaming now, but our voices aren't loud enough, yet. Listen for the sound though. It's a low rumbling noise. As if the underbelly of the nation was filling with noxious gases. Little flare-ups occur.

It starts with the proliferation of gangs, crime, drugs and small clusters of lost and angry little people—like the underpaid, the unemployed, the homeless, the hungry, the mentally ill, the forgotten elders, the ripped-off infirm, the flim flammed consumer and bamboozled constituents who huddle in gerrymandered abutments of this country.

You may see an occasional eruption—nothing to worry about, though. Not for awhile, anyway.

But maybe someday, hopefully, we, the people will stand up en mass and scream together, "We want democracy!" just like those people in China and Russia are doing today.

Then we can begin. First we'll vote "No" on incumbent for 10 years in a row: goodbye third party. Goodbye legal parasites and pocket Politicians and privileged few and power-mad egomaniacs.

We'll choose our leaders from the ordinary working class folks. (Now, there's a novel idea, right Mr. Jefferson?) Oh, and no lawyers . . . Shakespeare was correct when he said they all should hang.

For now, though, sit back. It's no big deal . . . this third party piece in The Union. Not to worry folks, until you can't stand the smell one more second. Could be years from now. Pass the dip'n chips, Paw, and switch channels will ya?

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Re: Medicate Catastrophic Act 1988

Dear Senator Bentsen: In my wildest imagination, I cannot understand how you could have loaded those of us on Medicare down with absorbing the cost of catastrophic medical care. The financial repercussions of this funding will hurt most of us financially.

Since Medicare is giving us less and less and our secondary insurance is picking up the balance of these charges, you are more than compounding our financial output, while we hold the bag. . . .

I, along with most of my friends are most hopeful that you will change the Medicare Catastrophic Act of 1988, so that the cost we will pick up will be modified in such a way that it will not be as burdensome as you have caused it to be.

If this is the way we are being served with our representatives in Washington, then it is high time we voted all incumbents out with each election.

Very truly yours,

LOUISE BREVERLY.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen: I want to go on record as one who protests the Catastrophic Insurance Bill.

I already am paying for adequate health care insurance.

I have worked hard, and am still working to provide for myself and pay my own bills, and I resent the Government's extorting money from me to pay for insurance coverage I do not want or need.

Sincerely,

Jean Brown.

Senator **Lloyd Bentsen**,
Chairman, Senate Finance Committee,
Washington, DC.

Dear Senator: We are both senior citizens and do not agree with the present provisions of the Medicare Catastrophic Act of 1988.

I am retired from the State of California and my wife and I are already covered with enough insurance. We feel that we should have the option of choosing, or rejecting, new coverage which in no way would be beneficial to us.

Please assist us in preventing the injustice of paying for insurance which we could not receive any benefit from.

Respectfully yours,

Les and Roberta Brown.

Senator **Lloyd Bentsen**,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Senator Bentsen: I am AGAINST the CATASTROPHIC HEALTH BILL!

Robert M. Brown.

Senator **Lloyd Bentsen**,
Chairman, Senate Finance Committee,
Dirksen Office Bldg.,
Washington, DC.

RE: Medicare CATASTROPHIC Act

Dear Senator Bentsen: OLD people like us are taxed going and coming. When we moved into this mobile home park bordering another county, we paid an "impact" tax whether or not we had young children going to school. We are still assessed monthly for new school taxes even though everyone (DMV, IRS, etc.) knows we are in our '70s.

The Catastrophic Act will mean we are taxed in ever increasing amounts early for medical care for Aids patients and the "Homeless" (largely skid row winos) including mentally ill people. As for the mentally ill people—Ronald Reagan set this up years ago when he was governor—and all I can say is I hope he gets caught in this tax trap. As for the Aids people and the winos—their problems are not my fault so why should I/we pay for their health care?

If all these people must be cared for by tax payers, especially OLD taxpayers, I suggest:

1. Old people should be exempt from school taxes and impact taxes; and/or
2. Aids, "Homeless" and mentally ill people should be cared for across the board by *all* taxpayers, not just the OLD people.

Inasmuch as we already have supplemental health insurance, we will be taxed for something we don't want and can't use.

Remember what you have heard about the "Greying" of America. Next election day will demonstrate the anger and hatred of many OLD people if this bill is not rescinded or modified.

James and Marge Bryant.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Re: Medicare Catastrophic Act of 1988

Dear Senator Bentsen: The purpose of this letter is to express our outrage at the discriminatory tax imposed by the subject Act. My wife and I have worked and planned for our retirement for many years, and because we have been reasonably successful, we have been thrust willy nilly into the most highly taxed group in the United States. *No one,* no matter how high his or her income, will be taxed at as high a rate as we will unless he or she is also 65 or older!

We do not question the principle of paying taxes for programs from which we do not directly benefit but which benefit us indirectly by helping our society. We may grumble, but we do not really object to contributing tax money for schools, welfare and other social programs. By the same token, we do not understand why in this sole instance, the group which is to be benefited is expected to carry the entire burden, by paying income taxes at a higher rate than any other group in the entire country!

Please do not try to tell us that this tax is a form of insurance. Insurance is voluntary, purchased on the basis of anticipated need. A forced payment is a tax.

If taxes must be raised to finance this program, at least let it depend more on income than on age! As it is, we are being forced to pay income taxes on so-called tax exempt Municipal bonds, something no other age group is being forced to do. How do you think that is going to help municipalities who are trying to borrow money for significant projects.

Please do what you can about this unfair, discriminatory tax!

Sincerely,

STANLEY C. AND NADA L. BURKET.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Bldg.,
Washington DC.

Dear Senator Bentsen: You are currently holding hearings regarding PL 100-360, the truly catastrophic Medicare Catastrophic Act of 1988. I just wish adequate bearings had been held before this law was passed. This is a law which gives me absolutely NO benefits but which increases my income tax by 15% this year and 25% next, with more increases to come.

I already have life time medical benefits for my dependents and me as a retired Navy captain with 29 years of active Navy duty. In addition, I have Blue Cross/Blue Shield from the State of California as a retired State employee with 18 yearn of State service.

I understand that the principal beneficiaries will be people with AIDS who consume costly drugs, perhaps $10,000 worth a year, and practically none of them will ever be 65 years old and subject to this insane tax on us who are over 65.

Please repeal that law quickly and start over. I am glad that I buy my own automobile insurance and home owners insurance. I am glad to buy my own medical insurance. Let others do the same.

Sincerely,

J.C. BURRILL.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Building,
Washington, DC.

Dear Senator Bentsen: We protest most vehemently the imposition of the highly discriminatory surtax to fund the Medicare Catastrophic Coverage Act of 1988 (CATCAP). This totally unfair additional tax upon a small segment of the population for the benefit of the many is unconscionable.

CATCAP itself is a badly flawed Act and should be rescinded. The lack of long term custodial nursing home care, reduced coverage, increasing deductibles, services available to all MEDICARE and AIDS patients, ever increasing costs and mandatory participation are but a few of the many flaws that must be corrected if any catastrophic care coverage for the elderly is to have merit.

The ultimate insult to those senior citizens who have spent their lives preparing for retirement without dependency on governmental largesse is the Supplemental Premium to fund CATCAP which is nothing more than a discriminatory tax to pay for care to those who have contributed nothing.

You must take action to correct these inequities.

Sincerely,

WILLIAM T. BYERLY AND E. JANE BYERLY.

CALIFORNIA FACULTY ASSOCIATION

RESOLUTION ON MEDICARE/CATASTROPHIC ILLNESS COVERAGE

COMMITTEE ON RETIRED FACULTY

WHEREAS, Congress has passed and President Reagan has signed House Resolution 2470 (P.L. 100-360, July 1, 1988), the Medicare catastrophic protection Act of 1988, in order to protect the nation's 32.4 million Medicare beneficiaries against catastrophic hospital and medical costs; and

WHEREAS, the act was designed to benefit the less than 1 per cent of the Medicare beneficiaries who are hospitalized annually for longer than 60 days and the 1 percent of beneficiaries who pay more than $1,370 annually in out-of-pocket expenses under Medicare, Part B, Physicians' Services and

WHEREAS, the act added partial coverage for prescription drugs, which will benefit only 17 percent of Medicare recipients and

WHEREAS, all Medicare beneficiaries, beginning in 1989, will pay an additional $4 a month Medicare, Part B premium for catastrophic coverage; and

WHEREAS, an estimated 44 per cent of Medicare beneficiaries, or 14,300,000 individuals, will pay an additional catastrophic coverage surtax of $22.50 on each $150 of Federal tax liability; and,

WHEREAS, this is 15 percent surtax could amount to as much as $800 per annum for a single person and $1,600 for a couple, rising to a 28 percent surtax by 1993, and

WHEREAS, the California Faculty Association finds growing dissatisfaction among its retired membership. as well as the state's four million senior citizens, with the financing provisions of the act; now, therefore, be it

Resolved by the California Faculty Association Assembly. That the California Legislature be requested to memorialize the President and Congress to take immediate action to amend the Medicare Catastrophic Protection Act; and be it further

Resolved, that the amendment to the act distribute the costs of the act's new benefits proportionately and fairly among current and future Medicare beneficiaries as has been previously the practice with both Medicare and Social Security; and be it further

Resolved, that the California Faculty Association transmit copies of this resolution to all members of the California Legislature; to the President of the United States; to the Members of Congress; to the print and broadcast media of California, and to other interested parties; and be it further

Resolved, that the California Faculty Association requests its national affiliates, SEIU, NEA, and AAUP to act in support of this California Faculty Association position.

CFA OPPOSITION TO THE FUNDING PROVISIONS OF THE CATASTROPHIC ACT

The California Faculty Association is strongly opposed to the funding provisions of the Catastrophic Act for the following reasons:

(1) The surtax is a staggering burden on middle-income seniors. imposing higher marginal tax rates than for any other group in the economy. It is unfair to impose the entire funding burden of the surtax on the elderly who have retired on fixed income and who have worked and saved to attain a modest degree of independence in their retirement years.

(2) It is unfair to impose this "user charge" on those who had already earned comparable health retirement benefits in their jobs, having given up salary to get those benefits. Because they will not receive any new benefits, a "user

charge" is inappropriate and should not be levied on public sector or private sector retirees in this category.

Congress should repeal the surtax and restore the traditional insurance financing principles of funding the Medicare program, spreading the cost over all potential beneficiaries.

California Retired County Employees Association

Hon. Lloyd Bentsen,
Chairman, Senate Finance Committee,
Dirksen Office Building,
Washington, DC.

Re: Public Law 100-360

Dear Senator Bentsen: On behalf of the nineteen California counties that are members of the California Retired County Employees Association (CRCEA), we wish to thank you and the other members of the Senate for listening to our complaints about Public Law 100-360—The Medicare Catastrophic Coverage Act of 1988. We appreciate the hearing that the Senate Finance Committee held on this matter on June 1, 1989 and the opportunity we had to observe that hearing on television.

Adequate and affordable health care always has been—and will continue to be—one of the primary concerns of the more than 100,000 local governmental retirees and spouses who are members of our various county associations. Our initial interest and support for legislation to broaden Medicare coverage was directed toward the problem of long-term care. The final product—as reflected in PL 100-360—was something we had not asked for, did not need and did not want. That is the consensus of our member county associations since our retirees already have excellent Medicap policies that equal or exceed the benefits provided in PL 100-360.

One of the major complaints about PL 100-360 was the lack of grass root participation in its formation. Now that this matter has been opened up for additional consideration, we would like to respectfully request that the problem of grass root participation be addressed. We believe it is imperative that hearings be held at the regional level as well as in Washington. In this regard, it should be noted that a request for at least two (2) hearings in California where grass root organizations such as CRCEA would be provided an opportunity to testify has been submitted by the California State Legislature through its adoption of Assembly Joint Resolution 6.

In press Release H-29 which was issued on May 23, 1989, it was indicated that a key concern of the Senate Finance Committee hearing would be the treatment of excess revenues that are expected to be collected. During the hearing on June 1st, there was some discussion regarding the quality of the revenue estimates—and some disagreement as to whether the rates should be reduced at this time. In this regard we want to comment that this is only a very minor problem at most—and we are concerned that it may obscure one of the real issues which is the inequitable means of financing.

We also want to comment that we concur with the testimony submitted by Senators Wallop and McCain regarding the compulsory provisions of the Act. Many of we seniors—particularly those of us who already have adequate Medicap insurance policies—strongly believe that serious consideration needs to be given to eliminating the compulsory coverage requirement.

In closing, I want to reiterate our request for regional hearing and an opportunity for CRCEA to present testimony reflecting the grass root sentiments of our membership.

Respectfully Submitted,

H.B. White,
Chairman, CRCEA Legislative Committee.

CALIFORNIA STATE ASSEMBLY COMMITTEE ON PUBLIC EMPLOYEES, RETIREMENT, AND SOCIAL SECURITY

Hon. LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Dirksen Bldg.,
Washington, DC.

Dear Senator Bentsen: The California State Assembly Committee on Public Employees, Retirement and Social Security, which I Chair, hears all bills pertaining to public employee retirement and health care benefits. On October 20, 1988, my committee held a special interim hearing on the impact that the Medicare Catastrophic Coverage Act would have on retired public employees in California. As a result of the testimony received at our hearing, I introduced Assembly Joint Resolution (AJR 6) calling for additional Congressional hearings on the Medicare Catastrophic Act to be held in California and for a one year moratorium on the implementation of the income tax surcharge. The hearings and moratorium are to study the impact on public employees and others who already have catastrophic health coverage which is superior to that provided by Medicare. A copy of the hearing transcript and my AJR 6 are enclosed.

California administers the Public Employees Medical and Hospital Care Act (PEMHCA) which covers all active and retired state employees, and many local government employees, both active and retired. All PEMHCA plans have excellent and thorough Medicare supplemental coverage which goes into effect when an employee becomes eligible. PEMHCA also requires the employer to make the same contribution towards health care premiums for retired employees as it does for active employees. In other words, as a result of good faith bargaining over the years, many public employees in California have health benefit coverage in retirement which far exceeds the benefits in the Medicare Catastrophic Coverage Act. These employees, however, because of the current funding structure, will have to pay the Medicare surtax even though they will never need nor use the benefits provided by the Act.

It was pleasing to hear that you are going to be conducting hearings on this issue. While the benefits offered through the Medicare Catastrophic Coverage Act will undoubtedly aid those individuals who have no other alternative health insurance, some dispensation should be made for those who have forgone other benefits in the collective bargaining process in order to obtain health benefits in retirement.

On behalf of California public employees, I urge you to reconsider the current funding structure of the Medicare Catastrophic Coverage Act and to conduct hearings on this issue in California.

Sincerely,

DAVE ELDER,
Chairman, Public Employees, Retirement and Social Security Committee.

CALIFORNIA STATE EMPLOYEES' ASSOCIATION
LOCAL 1000 • SERVICE EMPLOYEES INTERNATIONAL UNION • AFL-CIO, CLC

EMERGENCY BOARD RESOLUTION TO PETITION THE PRESIDENT OF THE UNITED STATES AND THE CONGRESS TO AMEND THE MEDICARE CATASTROPHIC CARE ACT OF 1988

SUBMITTED BY: CSEA Board of Directors

Amended and Adopted by: CSEA Member Benefits Committee

Amended and Adopted by: CSEA General Council, October 10, 1988

WHEREAS, (1) on July 1, 1988, President Reagan signed into law House Resolution #2470, Public Law 100-360, July 1, 1988, the intent of which was to protect the Nations' 32.4 million Medicare beneficiaries against long-term hospital care and expensive medical costs; and

WHEREAS, (2) the benefits of the Catastrophic Act are to be FULLY FINANCED by Medicare beneficiaries through a combination of increased flat premium (presently Part B) and a supplemental surtax on an individuals' tax liability, effective January 1, 1989, and increasing each year until 1993 at which time additional tax burdens could be imposed upon the elderly; and

WHEREAS, (3) the supplemental surtax will be paid by approximately 40% of Medicare beneficiaries who pay income taxes, while the remaining 60% and certain disabled beneficiaries under the age 65 and, Medicaid Recipients; Title III page 748-provisions Relating to the Medicaid Program, will begain coverage in 1989 of 85 percent, increasing to 100 percent in 1992, are exempted from payment; and

WHEREAS, (4) this supplemental surtax will start at 15% of every $150 paid in federal income taxes and will increase to 28% of tax liability in 1993, with an expectation of one percentage point added every year thereafter; and

WHEREAS, (5) an individual Medicare beneficiary could pay a maximum of $800 in 1989, increasing to $1050 in 1993 and a couple could pay $1600 and $2100 respectively; and

WHEREAS, (6)the flat monthly premium will increase for all Medicare beneficiaries over and above what is already being charged, from $4 per individual in 1989 to $10.20 in 1993; and

WHEREAS, (7) the Act has been designed that it will benefit only the one percent of beneficiaries who are hospitalized more then 60 days annually, and will benefit only the seven percent who exceed the $1,370 out-of-pocket deduction for physicians' services, and will benefit only seventeen percent by its partial coverage for prescription drugs; and

WHEREAS, (8) this law abandons the traditional social insurance model which spreads the cost among employers, employees and the self employed; and

WHEREAS, (9) this Act will add little to the excellent coverage the retirees of the State of California already receive through the PERS Medicare supplemental plans, and

WHEREAS, (10) the members of CSEA Retirees' Division are gravely concerned that the unfair funding of this Act will result in a fast erosion of their retirement pensions, and

WHEREAS, (11) this Act does not provide protection for senior citizens from impoverishing costs of long-term home or custodial care as the title, Catastrophic Care Act might imply; and

WHEREAS, (12) the United States Congress in their preparation of this bill on page 696 (c) gave federal retirees an exclusion amount (single taxpayers $6000 and joint taxpayers $9000) which is unfair and discriminates against city, county and, state civil service employees, and

WHEREAS, (13) Public Law 100-360 on page 697 states: "A" Not Treated As a Medical Expense - For purposes of Section 213, the supplemental premium imposed by this section for any taxable year shall not be treated as an expense paid for medical care, which is extremely unfair to the Elderly American Taxpayers, now therefore be it

RESOLVED, (a) that the California State Employees Association request the California Legislature to petition the President and the Congress to take action to introduce federal legislation to immediately stop implementation of Public Law 100-360 CATCAP in its present form and to develop a new method of financing that will involve all American Taxpayers on an equal basis, and be it further

Resolved, (b) that a copy of this resolution be sent to Californias' Congressional Representatives with a request that they take the lead in amending the Act to distribute the cost proportionately and fairly among current and future Medicare beneficiaries and, that they advise CSEA as to their position on this resolution, and be it further

RESOLVED, (c) that a copy of this resolution be sent to SEIU, to which CSEA is affiliated, requesting that they use their strong lobbying operation in Congress to seek a one years delay in the implementation of Public Law 100-360 CATCAP and, to ask for a bipartisan commission of Congress to conduct an in-depth analysis of the financing provisions of this law in order to establish a method of financing involving all American Taxpayers on an equal basis, (ie) a one percent surcharge on all tax returns, and be it further

RESOLVED, (d) that this resolution be given the widest distribution to the print and broadcast media of California and, to all interested parties.

GENERAL COUNCIL ACTION: Amended and Adopted, October 10, 1988

Citizens for a Sound Economy

Citizens for a Sound Economy (CSE) is an independent, nonpartisan, grassroots citizens' organization dedicated to solving pressing public policy problems in ways that promote economic growth and opportunity. Our members and supporters—250,000 Americans from every state and congressional district in the nation—contribute small amounts each year to fund CSE's activities. In spite of their limited resources, our members are making sacrifices to promote sound economic policies in Washington. Their trust is something we take very seriously.

Our membership includes Americans from all walks of life—from young professionals just starting their careers to retired persons with time to be active in civic affairs. We come before this committee not as a representative of any special interest, but as a representative of *all* our members, American taxpayers who care very deeply for the well-being of this nation.

CSE believes that the American citizens' voice has been ignored in Washington's catastrophic health care debate. Inside the beltway, when the catastrophic bill first began to take shape, the conventional wisdom suggested that the elderly favored the legislation and could not do without it. But now senior citizens are in an uproar. Many demand that the government reconsider the gigantic catastrophic health care bill.

CSE has been flooded with letters from our members criticizing the catastrophic care program. We would like to share a few of their comments with you.

Drew Barrett Jr. of Daphne, Alabama, wrote:

> The Barretts are on a fixed income; and have just been slapped with a 15 percent tax increase in the form of the diabolic Congressional/Presidential action entitled the Medicare Catastrophic Coverage Act (MCCA) . . . any additional legislation built on as weak a foundation as MCCA will be even more of a disaster

Similarly, Virginia Bond of Clearwater, Florida told us:

> I started to work 64 years ago for $10 per week and because I saved all my life so as to be able to take care of myself and not be a burden to anyone, I get penalized! And now I'm being faced with a catastrophic tax. We are being robbed!

Appendix A contains other comments of CSE members.

We believe that the Finance Committee has taken a commendable first step in opening hearings on the financing of the catastrophic health care program. This issue has great significance for our members, for millions of older Americans, for the baby-boomers, and for generations of Americans yet to come.

On their behalf, we urge the committee to recommend a repeal of Medicare's catastrophic care provisions and the establishment of a commission willing to consider private-sector alternatives to the current program.

The 1988 catastrophic health care bill claimed to insure the elderly and the disabled against the possibility of having their savings wiped out by large medical expenses. There are two major catastrophic health care expenses: acute care and long-term care. Acute care is the cost incurred while in the hospital, and long-term care is the cost of staying at a nursing home or other extended stay facility. The 1988 catastrophic bill extended acute-care coverage significantly while making only a modest attempt to provide coverage to seniors for catastrophic long-term costs.

There are several inherent problems with the government's attempt to provide catastrophic coverage. First, the government assumes that it can best decide what any individual needs, regardless of his own unique circumstance. However, we all know that no one has enough information to solve a problem for anyone better than he can solve it for himself. The best catastrophic policy is one that allows people freedom to buy the catastrophic coverage that they want, if they want it at all. Private insurance companies in an effort to out do each other will create various packages of catastrophic coverage which in turn will allow each American to choose his own program. Private companies can respond better to consumer needs than a particular plan mandated by the government. Also, by refraining from requiring people to pay for benefits they do not want, we can reduce the overall cost of catastrophic coverage.

Second, the program represents a punitive tax on many of the elderly to address a problem that was blown out of proportion. Many people already had catastrophic coverage. Seventy-seven percent of the seniors who pay the supplemental premiums already had the same benefits provided privately.[1] The poorest 11 percent of the enrollees already benefited from catastrophic coverage through Medicaid.

Further, another 1.2 million low income people will have their Medicare catastrophic premiums paid through Medicaid when the program is fully phased in.[2] Therefore, the ability of these poor people to pay for the program, which was one of the justifications for the compulsory measure, is not a critical issue, since other government programs are to a large degree paying for the poor's benefits.

Third, the present system is simply not worth the taxpayer's money. It is not a good deal. In 1989, expected benefits for each senior enrollee are $46.87, while average costs of the premium and surtax is $48. In 1993, when all the benefits are phased in, the only people who will have a net benefit from the program are singles earning under $9,500 and couples earning under $17,500.[3]

Besides being a bad deal, the present catastrophic program will face financial troubles in the near future. Primarily, the bill extends previous Medicare programs. Since we will not be able to afford present Medicare benefits in the near future, we should be wary of extending benefits.

The cost of the existing Medicare system is already skyrocketing. Medicare funds generated from Social Security taxes have risen from $17.90 a month per person in 1987 to $31.90 a month in 1989, an increase of 78 percent.[4]

In 1968, Medicare consumed 2.6 percent of the Federal budget. In 1988, it consumed 7.5 percent of the budget. By 1993, when all catastrophic benefits are phased in, Medicare will consume 10.6 percent of the Federal budget.[5]

There is no relief in sight from the Medicare tax burden. The Congressional Budget Office estimates that new Medicare benefits and administrative costs for fiscal years 1989-1993 will amount to $30.8 billion.[6] To support this level of benefits 45 years into the future, the payroll tax would have to increase from today's 2.9 percent to 6.6 percent.[7] Today, Medicare is predominantly paid for by a payroll tax. Total payroll taxes are currently 15.3 percent. Unless the system is changed, 43 percent of the money collected from payroll taxes will have to go to Medicare.[8] These Medicare cost escalations will leave us two options: raise taxes or cut benefits.

The catastrophic benefits in the 1988 bill may boost future Medicare costs even higher than anticipated. The bill extends insurance coverage to new areas, making it extremely difficult for policymakers to estimate the level of participation in these programs. Whenever incentives are changed, policymakers cannot use old participation rates to predict new rates of participation because these incentives influence people's decisions. For example, the deductibles that enrollees must pay for a hospital visit are limited to $564 a year in 1989. Previously, the number of hospital visits made determined the amount of deductibles the enrollee paid. People now have a much larger incentive to go to the hospital once they have paid the initial deductible. We have no idea how many more people will use hospitals because of this change.

Two trends will make the cost escalation inevitable. No national insurance policy provided by the government can escape the following realities that will bankrupt the present system. First, advances in medical technology will increase costs because doctors have an incentive to use the latest and not the most cost effective equipment. Hospitals and doctors ignore the cost of their services since their patients are only paying deductibles no matter what the cost of the program. This will bankrupt any social program that tries to extend care to those who can not afford it and leave health care costs so high only the rich will be able to afford it.

Second, Americans are living longer, so the number of senior citizens is increasing. Further, when baby boomers start to reach retirement age, their sheer numbers will exert a tremendous strain on the Medicare program. As the baby boomers become seniors, comparatively fewer workers will be supporting the system. Total

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[1] Peggy F. Hinchey, *Testimony of Senior Citizens Guild, Ann Arbor, MI, before the Republican Task Force on Health* (April 20, 1989).

[2] John Klem, chief actuary for the Social Security System, phone conversation (June 8, 1989).

[3] "The Insurance Value of Medicare's Catastrophic Benefits," *Institute for the Research on the Economics of Taxation Byline* (February 24, 1989), pp. 8–11.

[4] Peter Ferrara, "Abolish Medicare Taxes on the Elderly," *Cato Policy Analysis No. 115* (January 25, 1989), p. 8.

[5] David Wessel, "Rising Medicare Costs will go Under the Knife if Bush becomes President—or if Dukakis Does," *Wall Street Journal (Sept. 1, 1988).*

[6] Sandra Christensen and Rick Katsen, "Covering Catastrophic Expenses under Medicare," *Health Affairs* (Winter 1988), p. 82.

[7] Peter J. Ferrara, "Abolish Medicare Taxes," pp. 8–9.

[8] Office of Management and Budget, *Budget of the United States Government: Fiscal Year 1990* (Washington: USGPO, 1989). pp. 4–19.

Medicare costs will escalate because the increased senior population means that more people will be eligible for benefits with fewer people to pay for them.

Unless the present Medicare system is revised, these trends will crush the system. The government will be unable to pay for the pre-catastrophic benefits, not to mention the catastrophic care benefits of the 1988 bill. Expanding Medicare's benefits will hasten Medicare's fall into bankruptcy or induce the government to levy enormous taxes to pay for these benefits. Tax revenues generated for the Medicare program cannot sufficiently pay for the benefits the government now promises. Many experts predict that the mandatory portion of the program, which contains most of the acute care benefits, will go bankrupt within the next 15 years.[9]

Failure to restructure the system will postpone an inevitable decision. Let's not delay. We propose a responsible rethinking of the catastrophic bill. The most effective way to solve this problems is to tap America's entrepreneurial talent. Citizens for a Sound Economy believes that policymakers gave insufficient attention to the role the private sector could play in providing catastrophic health insurance, and greater private sector involvement should be part of the solution to the current problem.

If Congress is determined to put together a national catastrophic health-care plan, it should focus on making health insurance more affordable by easing the tax burden on those who choose to buy it.

There are many market-oriented approaches to solving this problem. However, I am not here to set forth a program of action. We do think a commission should be set up to study the problem and make sensible recommendations. For now, we should take steps to stop the regressive program that's coming into place.

Let's take a fresh approach to catastrophic coverage. Only by reviewing all possible solutions can we create a sound alternative to meet America's health care needs. Only by acting now can we avert an impending crisis.

APPENDIX A: CSE MEMBERS' COMMENTS ON CATASTROPHIC HEALTH CARE

Mr. Richard H. Leehouts of Kingsland, Texas:

> We who had saved and planned for retirement, who are on fixed income and least able to bear this burden, were selectively picked to pay for this benefit that over 70 percent of us don't need, don't want and can't pay for? . . . this law was a big mistake. I strongly urge you to review this legislation, reconsider and argue to delay implementation of this act for further repeal.

Mr. John H. Reddersen of Oceanside, New York:

> He [Sen. Bentsen] is said to believe the ruckus against this bill was generated by "wealthy retirees." He will need, apparently, to be convinced that there's a heck of a lot of retirees out there who are by no means filthy rich and who stand to be badly hurt by the 30 percent tax on taxes.

Mrs. Evelyn Hubert of Lufkin, Texas:

> (I) have done without many things so as to be able to take care of (my family). Now it will be taken from us, and we will be dependent on children much sooner than otherwise

Mrs. Eleanor Powers of Sherburne, New York:

> The catastrophic illness bill is a rip-off for the elderly.

Mr. Arch R. Shero of Rowlett, Texas:

> Seniors of all income levels are outraged over this affair. The benefits to seniors are virtually nil. . . . This new law is the rip-off of the century, a fact that will become obvious as younger persons reach retirement age! Help seniors get this legislation repealed.

Mr. Arnold Shaw of Lufkin, Texas:

> I am appalled that the AARP danced daintily around it for a long time and then pulled the old moth eaten ploy of having a survey done to dodge their responsibility. Hells bells! There are two glaring faults here—I'd bet a dummy hand grenade 90 percent of those ancients polled haven't the faintest idea what the act will cost them; and having been in this advertising

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[9] Peter J. Ferrara, "Abolish Medicare Taxes," p. 8.

agency racket 40 years, with many surveys behind me, the outcome can easily be manipulated by the phrasing of the questions.

Mr. and Mrs. George E. Deatherage of Bothell, Washington:

> The Social Security Catastrophic Insurance is something we two Senior Citizens do not need and do not want. However, if it is forced upon us we will stop all contributions to political candidates. We may even move to Canada or Mexico to get away from this excess taxation.

Mrs. Mildred T. Quier of San Diego, California:

> What I can do with the Medicare Catastrophic Insurance, I haven't the slightest idea.

Mr. and Mrs. Carmen Dickes of Lufkin, Texas:

> We are very much opposed to the Catastrophic Health Care! We think it is unfair to people like us that "did without" to try to save for our old age.

Mr. Frank L. Detemple of Camas, Washington:

> The President signed that new Catastrophic Act which is putting a tax on a tax. They gave us a little raise, then took it all away. Of 150 people attending a meeting on this new law, there wasn't a one that figured they had gotten anything, but to pay more. Some were pretty hot.

Mrs. Gladyce Manville of Ventura, California:

> Now the Congress has hit us with a huge raise in Social Security plus a tax upon a tax called a surtax. I have taken care of myself all of my life. Now that I have a little income we are being soaked for those who have squandered their assets.

Mr. Anthony Benedict of Antioch, Illinois:

> It is going to be catastrophic in the effect it will have on the income of many seniors such as myself.

Mrs. Ethel D. McCuthcan of Middletown, California:

> This piece of legislation (HR 2470, PL 100-360) is biased, ill conceived and disgraceful.

Mr. Otis E. Lock of Burnet, Texas:

> In regard to the elderly-ill who need help the most, the act does not live up to its title. Its confusing eligibility provisions defy comprehension, which leads to frustration and disappointment.

Mr. Matteo Milo of Bronx, New York:

> Congress will be faced with another Boston Tea Party, if they keep trying (to tax) the public as they have, in a few years to come. Taxpayers must be alerted to make themselves heard, to get results.

Mr. George Sargent of Bryn Mawr, Pennsylvania:

> I also oppose (The Catastrophic Health Care Program) because, like all giveaway plans, (it) will create an ever increasing recipient group as well as larger medical organizations to take advantage of the Federal government's largeness. All of this will be at the expense of those who had the foresight to work hard all their lives to provide for their own catastrophic medical costs. For them it is largely a duplication of expense.

Mrs. Vineta Whitmer of Chontican, Oklahoma:

> When I first heard of this—I could not believe that such an unfair program could be put into practice in America—U.S.A. When it was passed I felt as the early Americans expressed themselves in the Boston Tea Party. I feel betrayed.

Senator **Lloyd Bentsen**,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building
Washington, DC.

Senator Bentsen: I wish to add my voice to those who are *against* the so-called Catastrophic Health Bill.

Ruth Clindinin.

Senator **Lloyd Bentsen**,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building
Washington, DC.

Dear Senator Bentsen: We are strongly opposed to the Catastrophic tax on those of us who are sixty five years of age and over. We are referring to the Medicare Catastrophic Coverage Law.

Both of us worked our whole lives scrimping and saving so we could have money for retirement years. It is unfair and outright discrimination for retired persons to pay the bills for *all* Americans on Medicare.

The elderly have many heavy expenses that most younger people do not have. Below is a list that we have.

Prescription drugs. The cost of our prescriptions is in excess of one thousand dollars a year.

Dental bills. Older people need more dental work which can run into hundreds and even thousands of dollars.

Hearing aids. Two hearing aids, one for each ear, costs in excess of one thousand dollars.

Eye glasses, frames and repair work. Older people need eye glasses oftener than younger persons.

Cost of heating. Older persons need more heat.

Special diets. Earl is on a special diet which is costly.

The majority of elderly people who own their own homes probably live in older houses which require expensive repairs and upkeep. Most of the elderly are not physically able to do the repair work on their homes and must hire the work done.

Many of the elderly are no longer able to drive and must hire someone to take them to doctor and dental appointments, shopping and other places. They cannot expect friends and relatives to use their time, buy gasoline and do all the driving for them. Public transportation and taxi services are costly.

Many senior citizens are no longer able to do yard work and house work and must pay someone to do it for them. Many require in-home health care which is very expensive and rates for insurance for in-home health care are exorbitant.

Older persons require special health care supplies which most younger people do not need. These too are very expensive.

Hospital and life insurance rates are usually higher for the older person. Some insurance rates are according to age. The older one is the more they pay.

Both of us pay for hospitalization insurance, nursing care insurance and convalescent hospitalization insurance in hopes that we will not have to rely on the government to pay for such care if we need it.

Sincerely

Earl E. and Maurine I. Collison.

Senator **Lloyd Bentsen**,
Chairman, Senate Finance Committee,
Senator Dirsken Office Building,
Washington DC.

Dear Senator Bentsen:

I am writing to give you my serious objections to the cruel and unusual punishment being inflicted on us older Americans in the form of the current fake offer to provide Catastrophic Health Insurance. Since I am just about your age. I would hope that you could see things my way as a somewhat typical abused retiree. I have retired front Federal Civil Service and have health insurance coverage (Aetna) to adequately supplement my Medicare as the primary carrier. The "Catastrophic

Health" law adds no additional benefits but MUCH MORE COST in the way of a surtax; THE MOST UNFAIR FORM OF TAXATION for reduced-income retirees.

I know much political credit was passed around (in both parties) to support last years election but now that the smoke has cleared a fresh look should be taken at the gross unfairness of the whole concept of adding a surtax as a "users fee" for people who will mostly NOT USE the meager benefits provided under this law. I object to the concept of selective surtaxation and the Catastrophic Health Insurance law as an implementation of this unfair practice.

The following comments represent my view of this law:

> "The only CATASTROPHE experienced will be on my FORM 1040."
>
> I am 70 years old and live on a Civil Service retirement (net) of $1, 108/mo + Social Security for myself and wife . . . April 1990 scares me since I cannot save to pay a surtax next year!

I would like to buy the "HIGH OPTION" coverage offered by AETNA but with a surtax of about the same cost the Congress is making this unfair decision for me with dictatorial ruthlessness!

Since both the Democratic and the Republicans are claiming to espouse a "KINDER AND GENTLER" American, I don't see how you can do anything but rescind this unfair and SICK Piece of legislation!

Please be assured of my total sincerity in this personal matter; critical to the well being of myself and my spouse for our few remaining years.

Sincerely,

JOHN A. CONNOR.

4745 MOORPARK WAY
SACRAMENTO, CA 95842
JUNE 15, 1989

SENATOR LLOYD BENTSEN, CHAIRMAN
SENATE FINANCE COMMITTEE, ROOM 205,
SENATE DIRKSEN OFFICE BLDG.
WASHINGTON, D.C.

DEAR SENATOR BENTSEN,

IT HAS COME TO OUR ATTENTION THAT A LETTER ABOUT OUR FEELINGS CONCERNING THE MEDICARE CATASTROPHIC ACT OF 1988 SHOULD BE SENT TO YOU. MY HUSBAND AND I WORKED LONG AND HARD TO RAISE SEVEN CHILDREN, NEVER BEING ON WELFARE AND NEVER IN BANKRUPTCY. WE ARE FRANKLY SCARED THAT WE MAY LOSE OUR HOME.

WE HAVE PAID INCOME TAXES AS HIGH AS $10,000. AFTER THE KIDS GREW UP. NOW, WE ARE BOTH RETIRED, HAVE A MUCH SMALLER INCOME AND STILL PAY TAXES OF CLOSE TO $3,500. ALSO PAY HEALTH INSURANCE PREMIUMS OF $974. A YEAR. WHEN MR.COONS IS AGE 65, THE INS. PREMIUM WILL RISE TO OVER $1,357. A YEAR (PLUS MEDICARE GOES UP EVERY YEAR). THAT IS OVER $400. A MONTH THAT WE NEVER SEE.

I AM AN INSULIN DEPENDENT DIABETIC & MR.COONS HAS SUFFERED TWO HEART ATTACKS. SO, IN ADDITION TO HEALTH PREMIUMS, WE MUST CO-PAY EACH TIME WE VISIT THE DOCTOR AND PAY PART OF THE COSTS OF DRUGS AND INSULIN. SINCE WE ALREADY HAVE TWO HEALTH PLANS, IT IS VERY UNLIKELY THAT WE WOULD EVER BE ABLE TO BENEFIT FROM THE MEDICARE CATASTROPHIC ACT.

OUR ONLY INVESTMENT IS OUR HOME, WITH MORTGAGE PAYMENTS OF $ 484. A MONTH. IN THE EVENT THAT NOTHING IS DONE TO ALLEVIATE THIS UNFAIR SURTAX, WE COULD SELL OUR HOME AND LIVE ON THE PROCEEDS. HOWEVER, IT SEEMS INCONCEIVABLE THAT OUR GOVERNMENT OF THE PEOPLE, FOR THE PEOPLE AND BY THE PEOPLE INTENDS A TAX WHICH IS ONLY ON IT'S OLDER POPULATION. THE WORD ISN'T "UNFAIR" IT IS "OUTRAGEOUS".

PLEASE CONSIDER REPEALING THIS ACT AND COMING UP WITH A WORKABLE PLAN THAT WILL BE FAIR TO OUR OLDER GENERATION. MAY GOD BLESS YOUR EFFORTS !

SINCERELY,

Rhema D. Coons
RHEMA D. COONS
Darrell G. Coons
DARRELL G. COONS

5 COPIES EA.TO:
LAURA WILSON, HEARING ADMINISTRATOR✓
ED MILHALSKI, MINORITY STAFF DIRECTOR

Hon. LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen: This letter is written to urge Congress to enact immediately to provide a one year moratorium on the Federal tax surcharge to be levied under the Medicare Catastrophic Coverage Act.

The health care for the elderly should be borne by the population as a whole and not by a small segment of the elderly.

I'm 78; have worked all my adult life; have never been on welfare; and have a very sick wife (stroke and cancer).

Please add my position of support to those of the 35,000 members of the California State Employees Association (CSEA) in opposing the supplemental surtax on individual's tax liability.

Sincerely,

C. CARSON CONRAD.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Subject: Eliminate Medicare Catastrophic Act SURTAX

Dear Senator Bentsen: I respectfully urge your *support* for the *elimination of the SURTAX* and your continued efforts to finding a more equitable solution to the financing of the Medicare Catastrophic Act.

It seems to me, the people who need it the least (or not at all),are the ones who are singled out to pay for the other 60%. I worked hard and made many sacrifices along the way, in order to have a pleasant and worry free retirement and now the government wants me to take on the responsibility when I only planned for myself and family. It seems to me that everyone will someday benefit from this Catastrophic Act and why isn't everyone contributing to it?

PAUL CORELLA.

STATEMENT OF THE COUNCIL OF FORMER FEDERAL EXECUTIVES, SUBMITTED BY BUN B. BRAY, JR., PRESIDENT

Mr. Chairman: We are pleased to indicate to your Committee our reactions to the Catastrophic Health Insurance Act of 1988.

Our Council, made up of former top Federal Government officials in almost every facet of government, has been analyzing and is continuing to study the many different components of this P.L. 100-360.

We strongly urge the Congress to have this flawed piece of legislation changed.

- *The health coverage of this new law does not address the most critical health needs.*
- *The costs, related to benefits, are excessive.*
- *The method of financing the program is offensive, and certainly most discriminating.*

There are several important changes to be considered, which include:

ONE Revise the Health Benefit coverage to be more realistic in meeting the real health needs of persons age 65 and over. For example, this new law does not cover the most pressing problem facing seniors and their families, the cost of long-term custodial nursing home care.

Recent studies have been made that indicate a very small percentage of patients stay long enough in hospitals to warrant the use of this new legislation.

TWO Revise the system for financing the program so that the cost is *broad-based* and not paid largely by taxing approximately 40%, who must also carry the burden of the other 60%, of participants.

The Tax Reform Act of 1986 promised a maximum tax rate for Americans of 28 percent. As a result of this catastrophic illness legislation, the tax rate of the elderly goes up to 38%. For example, a couple with a taxable income of $36,000 would pay $6,000 in Federal income tax in 1989 and $900 Medicare surtax. In 1993 the couple will pay, under existing law, a Medicare surtax of $1,680.

THREE Hundreds of thousands—in fact, millions—of senior citizens *DO NOT WANT* and *DO NOT NEED* the coverage now automatically forced on them by this new Medicare program.

Some one-third of the Social Security participants have insurance which is equal to, or better than, that provided by P.L. 100-360; for example, Federal retirees already have comparable catastrophic coverage.

UNUSUAL FISCAL LOGIC!

The Medicare Catastrophic Act requires the Office of Personnel Management (OPM) to reduce the Federal Employee Benefit Program premium rates charged to Medicare-eligible annuitants. This was to insure that Medicare-eligible retirees would not be required to pay for duplicate benefits provided through Medicare and the individual insurance plans.

OPM made a determination that the value of the Medicare Catastrophic addition would amount to $3.1 per month for each Medicare-eligible who has both Part A and Part B of Medicare.

The General Accounting Office (GAO) also made a study and agreed that the $3.10 per month was a reasonable evaluation of the benefits for rebate purposes.

Overlooking the fact that the Medicare premium was increased by $4.00 per month,

> THE TRADE-OFF FOR THE FEDERAL RETIREE, WHO WOULD PAY THE MAXIMUM SURTAX OF $800 IN 1989, IS A REBATE OF $37.20 A YEAR.

Most unusual fiscal logic, may I say.

CRITICAL OBSERVATIONS

Mr. Chairman, in addition to the above, we have some observations which we wish to share with your Committee. In a published report one major organization said that four out of five Social Security recipients do not want the Catastrophic Health Insurance program.

Although there is considerable criticism that the Health plan fails to meet the critical health needs, it can be said that the preponderance of dissatisfaction is focussed on the method of financing the program. Generally, taxpayers recognize the need to carefully control the expenditure of funds for new programs because of the large budget deficit. The Catastrophic Health plan method of financing may have set an unfortunate precedent:

> to encourage and to promote the so-called "user fee" combined with a "means test" as a new tax reform method to finance other programs which are now supported by general taxation.

Some programs suggested for this treatment are:

A. The Savings and Loan industry "bailout"—the well-managed and prosperous organizations should be required to finance this and not the general taxpayer.

B. Child Care for working parents—these programs should be financed by the parents with children needing such care and not the general taxpayer.

C. Agricultural Support programs—these programs should be financed by the well-managed and prosperous farmers and not the general taxpayer.

D. Education—these programs should be financed by parents who have children attending schools and not the general taxpayer.

We wish to emphasize that *we are not advocating this kind of financing for the above programs.* However, if the Catastrophic Health plan method of financing remains in effect, the Congress will be faced with a powerful and growing demand for this kind of equal treatment from Social Security recipients and their families.

Our Council recognizes and supports some of the basic concepts of P.L. 100-360; but there is a definite and driving need to make drastic changes to this law; especially as to the method of financing.

Mr. Chairman, the more American seniors learn of this new health program, the greater the demand will be to make drastic changes.

We appreciate this opportunity to make known our views on this controversial issue, and stand ready to assist in providing our elder people a health plan that they *need,* that they *can* use, and that they *can afford.*

I thank you.

Senator **Lloyd Bentsen**,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen: How could you, or anyone else, consider a bill such as the Medicare Catastrophic Coverage Act of 1988 which would *cost a person more than the TOTAL INCOME he or she receives* from *Social Security payments* and *provides NOTHING* in return?

This situation could and will happen if the proposed Medical Catastrophic Coverage Act is approved as presented.

My example is a 65 year old retiree with a pension plan which was not coordinated with social security, but whose 65 year old wife is entitled to minimum Social Security payments. Total income for this family is $25,003 per year. The wife is currently entitled to $94.00 per month in Social Security payments. Of this amount $32.30 per month is deducted for Medicare, Part B, leaving payment of $62.00 per month. In the year 1990 her CATCAP Surtax will be approximately $937, which will make Medicare payments far exceed her *TOTAL SOCIAL SECURITY PAYMENTS.*

Since this lady has a supplemental health insurance plan, the Medicare Part B payments, as well as CATCAP Surtax payments provide absolutely NO BENEFITS to this family.

I sincerely urge you, and the Senate Finance Committee to reconsider, and eliminate the proposed Medicare Catastrophic Act of 1988.

Very Truly Yours,

Frank E. Covington.

The Senate Finance Committee,
Senator **Lloyd Bentsen**,
U.S. House of Representatives,
Washington, DC.

Dear Congressman: I am writing concerning the new Medicare Catastrophic Legislation. *I want it repealed. This is cross discrimination.*

It is totally unfair and not right to lay a age-targeted surtax on people who have worked hard all their lives meanwhile paying taxes and saving towards their retirement years. Now every thing we have saved will be double taxed.

The basic principle is wrong. If you are going to levee a tax it should be on all people equally. It is gross discrimination against the elderly middle class and people who have put their faith in Social Security to force this surtax on them. Most of us had no choice about paying into Social Security.

You have given us a prescription drug program that over 80% of us can't qualify for, and a catastrophic cap that 93% of us wonlt qualify for either. It is estimated that fewer than 4% will benefit from the expanded hospitalization.

The legislation is taxing the elderly to pay for the millions without insurance. This is gross discrimination. This includes AIDS victims, those with degenerative diseases, all the young people injured in car accidents, etc. as well as the elderly who haven't saved toward retirement.

We have our own insurance and it covers everything we need including prescription drugs, in-home care, and hospice. We won't receive any benefits what-so-ever from the Medicare Catastrophic Legislation The only thing we don't have is long term care and we wouldn't be getting that.

Please take another look at this catastrophe. It doesn't make any sense. Your attention to this concern is greatly appreciated.

Sincerely,

Cecil and Dorothy Creech.

Senator **Lloyd Bentsen**,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Sir: I am writing to you in regards to the CATASTROPHIC "Catastrophic Act" you and some of the other folks in Washington have seen fit to try and strap us with. When this idea was first being bandied about it actually sounded like something might truly be happening to assist older America with the tremendous burgeoning expense of maintaining their health and care. Unfortunately by the time that this so-called plan for helping this segment of society was about to be voted upon we were beginning to find out that it was going to be of little real use to a vast majority of citizens. Now this travesty has been voted into law and is about to be implemented and for many, many, many it is turning into a liability rather than an assist. We have paid high premiums of insurance, by choice, for years in order to assure the exact coverage that we are being forced to pay Medicare for this new "grand" Catastrophic Plan. It seems the only equitable way to handle this offering is to offer it to those people who wish to participate. Why should so many be forced to pay twice and/or for the few who have chosen to not concern themselves with their futures? This new tax liability that we will start paying is totally and completely an unfair taxation on a group of people who will have no recourse but to pay and pay if this law is not drastically modified.

I watched and listened to you during the presidential campaigns and I cannot believe that your committee cannot do something to abort this new law which has most of the over 60 citizens up in arms. This action must not be perpetrated on members of our society. When we worked and saved for so long our money must not go to pay taxes which will not serve us.

Hoping to soon hear in the news that things are happening to circumvent this "Act" going any further.

Sincerely,

MARILYN L. CURRY.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Building,
Washington, DC.

Dear Senator Bentsen: While visiting with a friend in Sacramento, I learned of your committee reviewing the Catastrophic Medicare Act of 1988.

I would like to voice my anger, along with many Senior Citizens, concerning the inequities of financial funding of this Act.

The pointed surtax directed to elderly middle class citizens overlooks the responsible Seniors who have budgeted to have supplemental coverage plus long term skilled nursing care insurance. Surely we should have an optional choice regarding acceptance of "Catastrophic Medicare" when already adequately covered, $2,600.00 in my case.

Very Truly Yours,

MRS. JULIA A. DAVIES.

Dear Senator Bentsen: Thank you for having hearings on the Medicare Coverage Act (MCA).

I am opposed to this unfair and probably illegal act. I feel that it is unconstitutional to implement a surtax and force me to buy something, that I don't want and don't need, and something I have double coverage from other sources.

The law ignores the real catastrophe the elderly face, which is long term home and nursing care.

The mandatory provision creates a dependency on the Federal Government where none existed before.

Surtax rates are open-ended. No one can predict how high the surtax may go. MCA is unpresidented in that it is to be funded by seniors who tried to plan so that they would not become government burdens in their old age. Taxing the 40% of seniors who pay income tax and will and will pay the 15% surtax to provide funding for several million disabled individuals under 65 is not fair.

MAC is grossly unfair and sends the wrong message to citizens regarding long-term planning for retirement.

Sincerely

KEITH J. DAVIS.

Enclosures.

A QUESTION OF FAIRNESS

Critics fault AARP on catastrophic care act

BY ELLIOT CARLSON

In what may be a record volume of mail, thousands of AARP members have protested the Association's decision to support the Medicare Catastrophic Coverage Act.

Since Congress enacted the law a year ago, AARP has received more than 55,000 member-letters about the program, most of them sharply critical of the new law and AARP's position.

The letters differ strikingly in tone. Some are thoughtful and well-reasoned while many others are shrill, even abusive. And quite frequently they're inaccurate on the new law's benefits, costs and AARP's role in the issue.

Overwhelmingly the letters object to the financing mechanism of the catastrophic program. And a sizable number are baffled that AARP could back legislation that included it. Hy Borman of Lake Worth, Fla., for instance, calls AARP's stand "a real boo-boo."

ILLUSTRATION BY STUART ARMSTRONG

The new law, to be phased in over five years, seeks to protect Medicare's 32 million enrollees from catastrophic costs by capping the amount they can be required to pay for hospital care, doctors' bills and other services covered by Medicare. It also includes a new drug benefit that takes effect in 1991.

In addition, the new law protects spouses of Medicaid nursing home residents against the threat of being forced into poverty. And it aids low-income elderly by requiring Medicaid, a joint federal-state welfare program, to absorb the costs of Medicare premiums, deductibles and coinsurance.

But the complaints aren't usually aimed at the benefits. Instead detractors focus on the financing. For the first time, beneficiaries themselves will pick up the tab for new benefits.

Many members object. "I do not deny the need to assist the elderly poor in this area," writes John Lawrence Gray of White, Ga. "The assistance, however, should come from all citizens, not just the middle and upper income elderly. To say that this is insurance is misleading. It is simply a tax increase on a limited segment of U.S. citizens."

"The new law is about as fair as raising taxes for blue-eyed persons and lowering them for those with brown eyes," says Frank Kurtz of Omaha, Neb.

Doris French of Jackson, Mich., criticizes the provision that requires those enrollees with higher incomes to pay a supplemental premium in addition to the basic $4 per month premium.

The supplemental, based on tax liability, will be paid by roughly 45 percent of beneficiaries (see stories on page one). Fifty-five percent will pay only the basic $4 monthly premium.

"So, here once more, we have a situation where the Congress of the United States has seen fit to clobber the middle income group," writes French.

"This method of collection really penalizes anyone who has saved some of his money and expected to use the interest for enjoyment," says Elmer Hallen of Kewaskum, Wis. "Now we'll have to use it to pay for this bill."

Other members write that it's unreasonable to pay for benefits they're already getting free from former employers, while still others don't think the program should be compulsory.

"Enrolling in Medicare Part B is optional," points out Rosemary Lucorburke of Petersburg, Va. "Why is it not optional to participate in the catastrophic health program?" Joseph St. Louis of Satellite Beach, Fla., asks, "What happened to my freedom of choice?"

Many writers complain that they weren't consulted about the legislation. "I fail to remember when I had the opportunity to express my opinion," writes Marjorie B. Smith of Meadville, Pa. Elisabeth S. Mateza of Boynton Beach, Fla., registers a similar complaint. "I have yet to encounter one individual who favors the law," she says.

Although the volume of mail represents only a small portion of AARP's membership, Association officials say they take the letters seriously. AARP's board of directors last April stated that it "has heard and shares the concerns of members with rising costs of health care, particularly with respect to the method of payment for the Medicare catastrophic health program."

The board continued that AARP remains "open to new proposals for funding the catastrophic program and will evaluate them in light of their equity and potential for support."

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2 June 1989
Sacramento Union

Catastrophic Act: A new Al Capone?

Are you old enough to remember the twenties and thirties during the era of Al Capone, Machine Gun Kelly and Pretty Boy Floyd?

This was a time when the Protection Rackets flourished under the control of the gang mobs, Mafia and others.

Our FBI and the Treasury Department eventually pretty well eliminated the Protection Racket, then, only to have it rear its ugly head again in 1988.

The only difference is that this time it is called the Medicare Catastrophic Coverage Act of 1988 (MCAA: Public Law 100-360) and it is legal! Yes, the MCCA is an updated version of the old Protection Racket, because if forces all of the 65 plus seniors to take it and pay for it whether or not we want it or need it.

For example, as a retiree from General Motors, my retirement package includes Catstrophic Medical insurance offered by a public insurance company for which I pay only $12.02 a month deducted from my pension.

This is a much better package than offered by Medicare's MCCA, both in coverage and cost.

Incidentally, there are probably several hundred thousand other G.M. retirees with the same coverage as well as many other non-G.M. retirees who neither want nor need MCCA, and if given the opportunity would overwhelmingly vote for repeal of MCCA.

I am sure this majority will also be voting for their Washington representatives that support repeal of MCCA and/or support of HR 63 sponsored by Representatives Bill Archer (Texas), and Rod Chandler (Washington).

I feel that it is downright unconstitutional to implement a surtax and force me to buy something, that I don't need and don't want, (MCCA Protection), and further something that I already have from another source.

If that isn't coercion and a form of a protection racket, I don't know what is.

Contrary to the American Association of Retired Person's (AARP) report of support of MCCA by their membership, MCCA is not supported by the majority of AARP members affected by the law (those over 65 who were not included in the survey).

I am a member of the AARP, am over 65 was not included in their survey and do not support MCCA.

The AARP has a MediGap Insurance program that handshakes with the MCCA.

Don't support Protection Racketeering, stand up and be counted, write to your senators and congressmen to repeal MCCA Public Law 100-360.

William G. Toland
Citrus Heights

Opinion/Analysis

Congress won't budge on unfair tax on seniors

Joan
Beck

If members of Congress ever shake their preoccupation with House Speaker Jim Wright's financial ethics, would it be asking too much for them to fix the flaws in that disastrous Medicare Catastrophic Coverage Act?

Seniors who hate the new law — and the steep surtax it levies on the incomes of middle-income elderly people — have done just about everything they can to push Congress to act except pay legislators handsome honoraria to play in golf tournaments or ante up $10,000 campaign contributions for the chance to talk to them over breakfast.

Opponents of the law have written hundreds of thousands of letters to members of Congress (my office is flooded with copies). They have prodded sympathetic legislators to introduce at least 15 bills to postpone or repeal or amend the unpopular law — and watched the proposals molder in committees.

They have circulated analyses by groups such as the Institute for Research on the Economics of Taxation that challenge misleading data issued by the federal government and the American Association of Retired Persons on the tax burdens and benefits of the Medicare expansion.

(The IRET says, for example, that "the Medicare Catastrophic Coverage Act is a bad deal for millions of the elderly. It will: cost the elderly more, on the average, than they can expect to receive in benefits; shift a portion of the nation's welfare burden from general taxpayers to elderly taxpayers; use much of the higher taxation of the elderly to pay for other federal spending; and raise the total cost of comprehensive health insurance.")

Seniors have also put together a Coalition for Affordable Health Care with 40 member organizations representing 18 tumote million people to amplify the voices they are raising to [illegible] st the act.

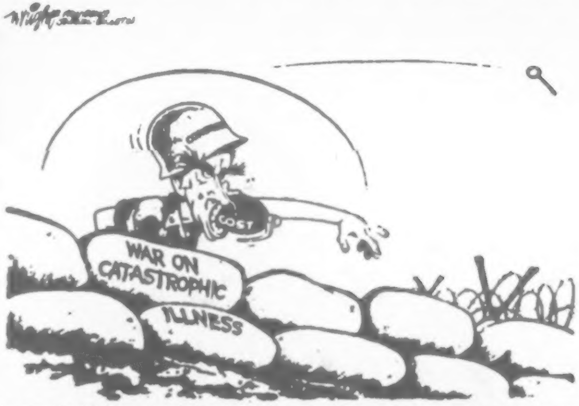
[illegible] congressional or administ-

favor the Medicare Catastrophic Coverage Act (as the AARP contends on the basis of a flawed poll taken last December), the Coalition for Affordable Health Care contracted for a nationwide telephone survey of a sampling of people at least 65 years old. It was conducted by the Wirthlin Group on May 9-11.

Only 30 percent of the elderly surveyed were aware of the new law; those who knew about it opposed the law by a 53 to 31 percent margin, with 30 percent indicating they were strongly against it. A majority of people in every one of the 29 demographic and geographic categories sampled opposed the new law — including lower-income seniors and those who do not have any kind of medigap insurance.

Even after pollsters listed six key provisions of the new law, 55 percent of the seniors surveyed said the benefits aren't worth the cost. After pollsters mentioned the new income tax surtax that will help pay for the new benefits, only 22 percent said the new coverage is worth the extra tab. Even a majority of lower-income seniors and of those who earlier had been in favor of the legislation now felt it is too expensive for what it will provide.

One finding confirmed a frequent complaint in seniors' letters to members of Congress: They already have insurance to supplement Medicare as part of their retirement benefits or have already bought a medigap policy and they resent being forced to pay higher taxes for unnec[illegible]ry coverage. Eighty-five percent of [illegible]



surveyed said they already have supplemental medical insurance.

A majority also said they would prefer to be covered by private health insurance instead of the deceptively named catastrophic plan. By a 65 to 19 percent margin, they told pollsters they would rather have financial protections against long-term nursing home costs than the benefits in the new act.

Seniors have tried with intelligent, reasoned, well-mannered arguments to convince Congress of the unfairness of the new legislation. They have pointed out that an income tax levied just on one age group is unprecedented. That it will hit hardest at the middle-income elderly, many of whom live on a carefully budgeted fixed income and are now socked with higher tax rates than anyone else in the nation. That the benefits promised [illegible] so loaded with catches [illegible]

They have also complained about some of the less obvious hooks in the legislation. For example, the elderly will be stuck with bills for disabled AIDS patients who are helped by costly drugs to survive for years. And through the wizardry of accounting, seniors' surtaxes will be used to make federal budget deficit figures look better, indirectly helping finance other government spending.

What else can the elderly do to push Congress to change this unpopular, expensive, unfair scam of a law? Now that they have used all the civics-textbook tactics, what's left to try is obvious: Offer a bunch of key members of Congress honoraria to speak at meetings or play golf in luxurious resorts or ante up some campaign contributions. That's what more experienced lobby groups often do to get legislators' attention.

Joan Beck is [illegible] columnist in Chi[illegible]

Senator LLOYD BENTSEN,
CHAIRMAN, SENATE FINANCE COMMITTEE,
Senate Dirksen Office Building,
Washington DC.

Dear Sir: As a senior citizen of these United States I object vehemently to the Medicare Catastrophic Act 1988. It is nothing more than robbery of we seniors. We have worked hard for our monies and now you don't want to let us spend it the way we have planned to. Its simply isn't fair in any way. I pray you will have a chance of heart and make this terrible injustus right. God help you and the men involved of the committee to correct this Act at this time.

Sincerely,

ANN AND ROBERT DAWSON.

Committee on Finance,
U.S. Senate,
Dirksen Building,
Washington, DC.

Dear Committee Members: I am responding to a press release that I received regarding the Medicare Catastrophic Health Act. This is a cruel hoax that has been played on the elderly.

Either the legislators did not really understand this act or if they did they hoped we could not figure it out. You keep saying, "But, it is so good for you." How can you possibly believe that when it may help only about 3% of the population? When you consider that the annual deductible is $2,540, I fail to see how anyone can pay that if they cannot afford medigap insurance that will' pay for everything. It would be interesting if someone could come up with a profile of someone that would really be saved from catastrophe with this bill, given all the statistics that we have uncovered. No one with medigap insurance would dare risk dropping it as that really could create a catastrophe. My Blue Cross Supplemental Insurance was increased by 10% in March, 1989. The rationale they gave me was their actuaries showed that this new law only paid 5% of their claims. On top of all this unfairness and misleading information now we are being hit with a 15% increase in our income tax that will go up each year. That is a real hardship on middle class elderly and we will not receive one cent in benefits. This law will raise billions and billions of dollars for you legislators to spend on who knows what—not the elderly. We want this law REPEALED!

We, of this generation, were brought up to believe in the integrity of our legislators but we have become very suspicious, now, with all this corruption that is coming out and we wonder how many special interest groups lobbied the legislators. We know for a fact that AARP was one of the big culprits. We have lost faith with them, too, as they no longer represent the interests of the elderly. They are promoting their insurance, drug and travel industries. Many, many persons are dropping their memberships in AARP. We have just been sabotaged.

The elderly are really furious about this matter but when April, 1990 comes and everyone is aware of the consequences, there will be a raging storm of protest for you to deal with. We elderly are no longer intimidated are active, informed, verbal—AND WE VOTE!

Yours truly,

ERNESTINE H. DAY.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Bldg.
Washington DC.

Dear Senator Bentsen: We stony protest the Medicare Catastrophic Act of 1988. It is very unfair to tax those of us over 65 when we can least afford it. We who have skimped and saved all our adult lives so we could care for ourselves on retirement are now hit with this bombshell. How could you do this to us?

Every social program that has been passed since FDR has cost much more than estimated and many times money has been siphoned off for other programs.

We urge you to see that this act is repealed and instead work toward reducing medical costs—doctor fees, hospital costs, nursing home costs, etc., This is where your efforts should lie after you repeal this act,

Sincerely,

MR. AND MRS. H. DIFFENBAUGH.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Dirksen Office Bldg.
Washington, DC.

Sir: This letter is to inform you of our displeasure with Medicare Catastrophic Coverage of 1988, (MCAA PUBLIC LAW 100-360).

This kind of health protection should be offered to those who wish that coverage and not "blanket-in" those who have already gotten their own coverage with another institution. Who knows better than I, what protection I want or need. At least let me make my own decision.

We wish to have MCAA PUBLIC LAW 100-360 repealed.

Sincerely,

DALE E. AND NORMA J. DINGER.

Senator Lloyd BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen: Please be advised that this letter is in *opposition* to the Medicare Catastrophic Act of 1988.

It is inconceivable that Congress could have passed a bill that places the burden of finance on such a small group of citizens (40% of seniors 65 years and older) and further is so designed that less than 7% of those who pay will receive any benefits of this poorly thought out bill.

How could a compassionate Congress have been so hoodwinked by a self-serving organization (AARP) claiming total support of its membership, when, in fact, the majority of members are opposed?

The content of this bill has been dismally published. Even today accountants cannot advise exactly who 65 years of age and older will be paying for this bill. Who *is* Medicare eligible? Most of the citizens who are definitely identified as responsible (those on Social Security) have already made arrangements or have retirement benefits covering catastrophic illness, and they therefore will ~~not~~ be eligible for benefits of this Act. What kind of Congress *forces* citizens to pay for insurance they cannot use at rates far exceeding what they could buy privately? Is this collusion?

It is deplorable that Congress has chosen to fractionalize Americans by age, thereby weakening support of one group for another.

Hopefully this committee will recommend repeal of this unfair Act. We will be following closely the decision and outcome of this group.

Sincerely,

JO ALICE AND EDWARD D. DOUGHTY.

Dear Senator/Congressman: As a senior constituent, I want to state in the strongest possible terms disapproval of the financial requirements of the Medicare Catastrophic Expansion Law (P.L. 100-360). We seniors have tolerated cuts, withdrawal of benefits and added taxes "without undue complaint. We have become the "Tolerant Generation." We were, probably, not expected to resist "whatever senior scheme Congress could contrive. Well, we are resisting. We are fighting mad that Congress would place the burden of paying for services for young and old alike on the shoulders of those age 65 or older. This "Supplemental Premium" is a heavy and discriminatory tax on senior citizens alone. We expect you to take action to correct the gross inequity of this law only on older Americans immediately.

Please notify me by return mail what specific corrective action you have taken on this matter.

Sincerely,

ROBERT DUNLAP.

STATEMENT OF EMERITUS AND RETIRED FACULTY ASSOCIATION BY MILTON DOBKIN, PRESIDENT ELECT

The membership of our organization strongly favors catastrophic health care for all Americans, but we also favor fairly and equitably financed programs to provide such care whenever the U.S. Government mandates such programs.

Current funding required for catastrophic health care programs is grossly unfair. It singles out, inequitably, those with annual incomes from $10,000 to $42,000 to carry the burden for all and assures that same amount as the already overtaxed middle class.

In addition, current reports of estimated revenue suggest that Act's surtax will be used as an inequitable way of reducing the general Federal deficit since the expected revenue total far exceeds the benefits to be provided.

The members of our Association are also dismayed by the unfairness of the Act's surtax on those whose strenuous efforts over many years have resulted in the "purchase" of benefits which are either duplicated by the Act or are greater than those provided by the Act. Specifically, many retirees who worked in or other State employment took health benefits in lieu of other compensation to protect themselves from future medical catastrophes. Their cash retirement benefits are, of course, smaller than they otherwise would have been as a consequence of that action. Now, with a projected premium return to them which can only be described as infinitesimal, the Act requires them to pay again for "benefits" for which they have already paid.

We do not object to assisting the less fortunate who need coverage, but we who already pay the greatest share of the revenues collected, and who are largely fixed income retirees (we are not the "greedy wealthy") insist that societal needs be met by society as a whole, rather than being visited on one segment of our society.

We urge amendment of the coverage and financing of the Catastrophic Health Care Act.

Hon. LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Sir: I am writing to protest the Medicare Catastrophic Act of 1988. It is the most ill-advised legislation I have seen in my lifetime.

The act does not provide any catastrophic health benefits for the majority of the elderly. It only taxes them catastrophically. Personally, I have private supplemental insurance that provides much better coverage.

The worst aspect of this legislation is the surtax placed on taxpayers 65 years of age or older. The tax is discriminatory and escalates every year based on a couples tax bill. As taxes rise, the surtax takes a bigger bite.

I can assure you that I am not wealthy. My taxable income in 1988 was $27,605. My tax bill was $4,144. As I am on a fixed income, my taxable income will remain about the same in 1989 and 1993. Because this surtax is double for a couple by 1993 the surtax is $45 per each $150 of taxes paid. It is double that amount for a couple or $90 per each $150 of taxes. My surtax could conceivably be $2,486 by 1993. That's a hell-of-a-lot of taxes for nothing in return. No other age group has ever been subjected to a surtax on income taxes (a tax on a tax). If Congress likes the idea of making possible beneficiaries pay for benefits, then only those with children in school should pay taxes to support the schools. Congressmen and government employees should thusly bear the cost of government.

In addition to the surtax, Medicare premiums were raised $4.00 ($8.00 per couple) in 1989 and will rise to $10.00 ($20 per couple) in the next four years.

I feel the entire legislation was enacted to reduce the budget deficit in an attempt to balance the budget Congress never had any intent to pass legislation that would benefit the elderly. I urge you to repeal the entire catastrophic Health bill. Believe me, The senior citizens will be watching every move of the Senate and House members in this regard.

Sincerely,

JACK M. ERICKSON.

STATEMENT OF FAIRNESS TO SENIORS COALITION (CALIFORNIA), BY TED RUHIG, PRESIDENT

Our Coalition, composed of 16 participating organizations representing California seniors, is strongly opposed to the funding provisions of the Catastrophic Act for the following reasons:

(1) The surtax is a staggering burden on middle-income seniors, imposing higher marginal tax rates than for any other group in the economy. It is unfair to impose the entire funding burden of the surtax on the elderly who have retired on fixed income and who have worked and saved to attain a modest degree of independence in their retirement years.

(2) It is unfair to impose this "user charge" on those who had already earned comparable health retirement benefits in their jobs, having given up salary to get those benefits. Because they will not receive any new benefits, a "user charge" is inappropriate and should not be levied on public sector or private sector retirees in this category.

Congress should repeal the surtax and restore the traditional insurance financing principles of funding the Medicare program, spreading the cost over all potential beneficiaries.

In addition, our Coalition urges that:

(1) Congress should amend the law to permit California to restore its previously existing standards for protection against spousal impoverishment based upon our state's community property laws.

(2) Congress should make long-term care the number one priority, recognizing the strong preference of seniors for home care rather than institutional care, to the maximum possible extent.

(3) Congress should take steps to ensure that taxes and charges be reduced to the level of program costs, and that the projected surplus be used to reduce taxes and charges to those scheduled to pay them.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Sir: We would like to add our names to the ever increasing Medicare recipients who are in opposition of the "Catastrophic Care" surtax.

We feel this new Medicare program is unfair, especially to the older citizens who have to bear the financial burden, and should be repealed, amended, or delayed for one year, pending review by Congress,

We ask you to support legislation to remove and change the supplemental "Catastrophic Care" surtax. This tax unjustly targets the elderly with a tax rate higher than any other segment of the population. It is also a penalty on seniors in good health who continue to work or seniors who must work to supplement retirement.

Sincerely,

MARVIN W. AND RUBY E. FERCHO.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen: A few days ago, I prepared the second installment of our 1989 estimated income tax, rechecking the figures to be sure I wouldn't get a penalty for underestimating. Then after arriving at the tax I added fifteen percent for the Catastrophic Medicare Tax, knowing we were sending that along to pay for something we don't want and don't need. A few years ago we bought a long term care package that provides everything Catastrophic Medicare does and more.

Since my wife and I are retired and living on a fixed income, these kinds of costs must be financed from existing resources. That means dipping into the small savings we had put aside and cutting into some "non-essentials," i.e. eating out less, renting fewer VCR movies, reducing recreational travel, minimizing home maintenance, etc. In other words cutting down on the quality of life. These items have already taken a beating due to inflation. And there are millions of others like us doing the same things for the same reasons. The points I am trying to make are these:

1. We are being penalized because we tried to save for our later years and we became 65 years old.
2. We are being forced to pay for a health (plan?) that does not provide what we need. In fact it doesn't do enough so that we can cancel the plan we already have. We must keep both at twice the expense.
3. We must pay with our existing resources. It is no longer possible to get more money by asking for a raise, or as the congress does, raise taxes. And in spite of the promise of no new taxes, Catastrophic Medicare is a new tax. In fact I think it is the biggest discriminatory tax increase to come along in years or perhaps ever.

In summary, it appears to me that this is an expensive program of little value to the vast majority. It should be repealed and a new plan devised and financed by cuts in present expenses. For these I'd suggest a review of the recommendations of the Grace Commission.

Sincerely,

RAYMOND G. FISCHER.

FUND FOR ASSURING AN INDEPENDENT RETIREMENT

MR. CHAIRMAN. MY NAME IS VINCENT R. SOMBROTTO. I AM CHAIRMAN OF THE FUND FOR ASSURING AN INDEPENDENT RETIREMENT (FAIR), A 32-MEMBER ORGANIZATION WHICH REPRESENTS OVER SIX MILLION ACTIVE AND RETIRED FEDERAL, POSTAL AND PUBLIC EMPLOYEES.

THANK YOU FOR HOLDING THESE IMPORTANT AND TIMELY HEARINGS. FEDERAL/POSTAL EMPLOYEES AND RETIREES ARE FULLY COVERED FOR CATASTROPHIC EXPENSES THROUGH THE FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM (FEHBP). THE PLAN, TO WHICH EMPLOYEES CONTRIBUTE, COVERS HOSPITALIZATION, DOCTORS' FEES, PRESCRIPTION DRUGS AND RELATED CHARGES.

THE ADDITIONAL BENEFITS IN P.L. 100-360, THE MEDICARE CATASTROPHIC ACT, REPRESENT COVERAGE THAT FEDERAL/POSTAL EMPLOYEES AND RETIREES NEITHER NEED NOR WISH TO PAY FOR. THE NEW LAW WILL RESULT IN RETIREES PAYING AN ADDITIONAL $4/MONTH FOR THE PART B MEDICARE COVERAGE, PLUS A SUPPLEMENTAL PREMIUM WHICH BEGINS IN 1990. BOTH OF THOSE COSTS WILL RISE DRAMATICALLY IN SUCCEEDING YEARS. ADDITIONALLY, AS GENERAL HEALTH COSTS RISE, RETIREES FACE RISING COSTS IN FEHBP. LAST YEAR, THAT INCREASE AVERAGED NEARLY 30 PERCENT FOR FEHBP PLANS. MR. CHAIRMAN, RETIREES FACE THESE COSTS WHILE LIVING ON FIXED INCOMES.

WHILE WE ARE GRATEFUL TO THE SENATE FOR ATTACHING TWO AMENDMENTS CRUCIAL TO FEDERAL RETIREE INTERESTS DURING CONSIDERATION OF THE LEGISLATION LAST YEAR, THE AMENDMENTS HAVE NOT ALLEVIATED THE PROBLEM. THE FIRST AMENDMENT PROVIDED A SPECIAL CREDIT TO REFLECT THE FACT THAT GOVERNMENT

ANNUITIES ARE TAXABLE WHILE SOCIAL SECURITY BENEFITS ARE LARGELY NOT TAXABLE. THE SECOND AMENDMENT SOUGHT TO ELIMINATE DUPLICATION OF COVERAGE BETWEEN THE FEHBP AND MEDICARE. THE NEW MEDICARE BENEFITS THAT BECAME EFFECTIVE JANUARY 1, 1989 HAVE RESULTED IN A $3.10 PER MONTH REBATE TO FEDERAL RETIREES WHO HAVE INCURRED THIS DUPLICATION OF COVERAGE. A RECENT REPORT FROM THE GENERAL ACCOUNTING OFFICE (GAO) INDICATES THAT THIS REBATE IS SUFFICIENT. BUT FEDERAL/ POSTAL RETIREES ARE JUSTIFIED IN CONTINUING THEIR OUTCRY. THIS SCENARIO FURTHER EMPHASIZES AND UNDERSCORES THEIR PERCEPTION THAT THEY REALLY ARE GETTING VERY LITTLE FOR THE EXTRA COSTS THEY WILL BE REQUIRED TO SHOULDER.

HOWEVER, OUR CONCERNS ARE THE SAME CONCERNS THAT MILLIONS OF OLDER AMERICANS FACE. SENIOR CITIZENS FEARS ARE THAT THEY WILL HAVE TO BEAR THE BURDEN FOR ADDITIONAL HEALTH CARE BENEFITS THAT MOST ALREADY HAVE. MOREOVER, THE CATASTROPHIC LAW DOES NOT ADDRESS OTHER HEALTH CONCERNS SUCH AS LONG TERM CARE. THE EXPENSES FOR LONG TERM CARE AT HOME AND IN NURSING HOMES ARE THOSE MOST APT TO BANKRUPT INDIVIDUALS AND ARE WHAT THE ELDERLY FEAR MOST. PROTECTION AGAINST LONG TERM CARE COSTS IS WHAT SENIOR CITIZENS VIEW AS "CATASTROPHIC" COVERAGE. SENIORS ARE WELL AWARE THAT THEY MUST SHARE IN THE COST FOR LONG TERM CARE INSURANCE, AND WE BELIEVE THEY ARE MORE THAN WILLING TO DO SO. YET, WE ALSO BELIEVE THAT THIS MANDATORY NEW ACUTE CARE COVERAGE HAS USED UP A HUGE PORTION OF BOTH THE WILLINGNESS AND THE RESOURCES

THEY WILL NEED TO PAY FOR LONG TERM CARE PROTECTION.

WE ALSO RECOGNIZE THE NEED AND RESPONSIBILITY TO PROVIDE ADEQUATE ACUTE CARE TO THOSE WHO ARE TRULY NEEDY. BUT THE COST OF PROVIDING THIS COVERAGE SHOULD BE SHARED BY ALL TAXPAYERS THROUGH A SYSTEM THAT ASSESSES THE COST FAIRLY; IT SHOULD NOT BE A RAPIDLY ESCALATING SURTAX THAT IMPOSES THE HIGHEST INCOME TAX RATES IN THE COUNTRY ON SENIOR CITIZENS.

THE OUTCRY AGAINST THE MEDICARE SURTAX IS NOT COMING JUST FROM "WEALTHY" SENIOR CITIZENS. DESPITE SOME RHETORIC, THE SURTAX BURDEN ON THE TRULY WEALTHY IS MINIMAL. THE MAXIMUM ANNUAL DOLLAR PREMIUM RESULTS IN A RAPIDLY DECREASING SURTAX PERCENTAGE FOR THE TRULY WEALTHY. IN FACT, IT IS THE MIDDLE INCOME ELDERLY WITH LIMITED TAX SHELTERS AND DEDUCTIONS WHO SUFFER ITS EFFECTS THE MOST.

WE BELIEVE THE FLAWS IN THE CATASTROPHIC LAW CANNOT BE SOLVED BY A DISCOUNTED SURTAX, ONLY BY A FULL REVIEW OF THE PLAN. BECAUSE OF THE MANNER IN WHICH THE SURTAX IS ALLOCATED, A DISCOUNTED SURTAX COULD ACTUALLY LEAVE THE LOWER AND MIDDLE CLASS RETIREES TO BEAR EVEN MORE OF THE TAX.

FAIR IS PLEASED BY YOUR COMMITMENT TO THOROUGHLY EXAMINE THIS ISSUE AND REACH A RESOLUTION BY SEPTEMBER. WE KNOW THAT THE ISSUE IS EXTREMELY COMPLEX. IF YOUR COMMITTEE IS UNABLE TO RESOLVE THESE PROBLEMS BY SEPTEMBER, A DELAY IN THE IMPLEMENTATION OF THE SURTAX WOULD BE BENEFICIAL. WE ARE READY TO WORK WITH YOU TO FIND SOLUTIONS TO PROBLEMS FACING FEDERAL/POSTAL RETIREES AS A RESULT OF THIS NEW COVERAGE.

LEGISLATIVE NEWS

BY: COL John M. Gabel
March 15, 1989

In preparing to write this article, I must confess to a feeling of complete helplessness and great anger due to the fact powerful members of the United States Senate and, the House of Representatives provide only half the truth or, completely inaccurate information about the Catastrophic Health Care Law, Public Law 100-360 and the laws effect on the elderly retired age 65+.

Further, it is next to impossible to have the true and accurate facts printed in the newspapers, the National magazines or discussed on television. It is obviously more important for the mass communication newspapers, magazines and television news commentators to discuss in detail the Homeless Street People; the Right for Women to have Abortions; the Drugs on the Street; and, the current status of AIDS victims.

Our Mass Media could care less about the appalling, dicrimative surtax's being extorted from the elderly age 65+ who pay federal income taxes of $150+. This unfair discriminatory supplemental surtax is paid by 40 percent of Medicare elgible while the other 60 percent, certain disabled Medicare beneficiaries under the age of 65, Medicaid recipients and, AIDS beneficiaries are entitled to receive benefits of the Catastrophic Health Care Law without payment.

The Catastrophic Health Care Law has been designed so it will benefit only one percent of the beneficiaries who are hospitalized more then 60 days annually, and will benefit only the seven percent who exceed the $1370 out-of-pocket deduction for physicians services, and will benefit only seventeen percent by its partial coverage for drugs after the huge deductable amount has been reached.

In the CONGRESSIONAL RECORD - SENATE dated June 8, 1988 S7414, comments by Senator Lloyd Bentsen, "The drug benefit is going to be phased in over a period of 3 years. But it will say to the elderly that one of the things that has been most expensive for you, will be covered by Medicare if your drug bills are greater than $600 in a year." Senator Bentsen does not state, once the deductable amount is reached, the Medicare beneficiary must still pay 50 percent Of the drug cost. Senator Bentsen continues, "And I remind my colleagues that of these benefit improvements will not cost the Treasury $1. This is not a bill that passes the costs on to the younger generation. The premiums will be paid by those people who are 65 years or older and who today are doing better financially than any other age group. The elderly are saying we are prepared to take care of ourselves, and we are willing to pay for these benefits to protect ourselves from the extraordinary, the catastrophic illness. And that is what this piece of legislation does." Senator Bentsen does not state, that only 40 percent on the elderly seniors age 65+ who worked hard and planned for their retirement on pensions, Social Security and interest from investments would be socked with the entire cost of the Catastrophic Health Care cost. Further, Senator Bentsen does not state, Disabled War Veterans entitled to treatment in Veterans Hospitals would be required to pay the supplemental surtax if they are Medicare elgible and are age 65+ and have taxes of $150.

In addition, retired members of the Armed Forces of the United States who were required to participate in the Social Security program by Congress when the Social Security funds were low, now find they qualify for benefits and at the age of 65 are required to give up their medical/hospital Champus coverage and participate in the Medicare program. As a result, they are also part of the Catastrophic Health Care Law participants and must pay the supplemental surtax for medical coverage even though promised medical benefits for the retiree and immediate family members during the period of retirement.

In addition, retired Civil Service employees of the Federal Government, States, Counties and Cities with health and hospital plans who have absolutely no reason to be covered by the Catastrophic Health Care Law, find they also are required to pay the supplemental surtax.

I am certain there are many others such as School Teachers and Unionized occupations who also provide medical and hospital benefits who will be unhappy about the supplemental surtax.

The Congress also built into this law a very discriminatory tax penalty directed at the elderly. The law states, "Not treated as a Medical Expense - For purposes of Section 213, the supplemental premium imposed by this section, for any taxable year shall not be treated as an expense paid for medical care." For example, if a commercial Health or Medical Plan was purchased, the costs would be tax deductable for payments made.

Senator Alan Cranston in the CONGRESSIONAL RECORD Vol 133 dated October 26, 1987 No. 168 had the following comments for the record, "Mr President, I would like to respond to one specific criticism of the drug benefit. Some opponents of the prescription drug benefit contend that it would result in senior citizens subsidizing the costs of drugs, such as AZT, for persons with AIDS. Frankly, that is just a totally inappropriate attempt at scaring senior citizens into apposing this amendment. Very few AIDS Patients are covered by Medicare, because tragically they generally do not live long enough to qualify. In order to be elgible for Medicare by virtue of total and permanent disability, an individual must wait 29 months after becoming disabled - and that is longer than most AIDS patients live. Medicaid, not Medicare is the major governmental payer of AZT costs." "Thus, Mr President, the opponents of this proposal should abandon these fallacious scare tactics immediately."

More recently, Senator Cranston in his publication, SENATOR ALAN CRANSTON REPORTS TO CALIFORNIA SENIORS, this is dated WINTER 1989 (sic) on page 4, What About Medicare for People With AIDS ?, "In order to receive Medicare catastrophic coverage benefits, people with AIDS must first qualify for Social Security Disability benefits. It then takes 24 months to gain Medicare entitlement. To date, fewer than 400 AIDS patients out of more than 80,000 individuals diagnosed nationally - have qualified for Medicare." Senator Cranston does not discuss the many AIDS patients now being taken care of under the Medicaid program that he mentions in his October 26, 1987 Congressional Record comments and, the fact that under the Catastrophic Health Care Law in 1989, this law pays 85 percent of the Medicaid costs.

In the publication discussed in the above paragraph, Senator Cranston has a chart titled, Impact of Catastrophic Coverage on enrollees, it is a surtax chart and very carefully printed at the bottom of the page is the comment (Credit A.A.R.P.)

Regarding the amount of income required to reach the maximum supplemental surtax, many different figures have been quoted. Ms Vicky M. Semones, M.P.A. a Program Specialist with the Department of Health & Human Services, Health Care Financing Administration of the US Government in a talk on August 20, 1988 distributed a two page governmental form to Northern California Council of Chapters, Retired Officers Association at the Presidio of San Francisco. Ms Semones talk on the Catastrophic Health Care Law, PL 100-360 was very interesting but, as we later determined, the figures given Government Form DPO-108 for the amount of income required to reach the maximum supplemental surtax was badly in error. All portions of her chart are in error but to indicate only the 1989 portion, the DPO-108 Form states, "Estimated Taxable Income (1989) of $19,047 will result in an Estimated Federal Tax Liability of $5333 which will require a Supplemental Medicare Surcharge of $800."

On the other hand, we have the erroneous figures distributed by the American Association of Retired Persons (A.A.R.P.) which states, "Impact of Catastrophic Coverage Act on Medicare Enrollees 1989" Single Enrollees Total Income $45,000 will result in a Taxable Income of $29,795 which will require a Supplemental Medicare Surcharge of $800." Married Enrollees, "Total Income $90,000 will result in a Taxable Income of $59,590 which will require a Supplemental Medicare Surcharge of $1600."

The most accurate and complete information on the Catastrophic Health Care Surtax is contained in the package of material released by The Retired Officers Association (National Legislative Office) as part of the Coalition for Affordable Health Care (CAHC) mailing. "Using gross income to describe who will pay the maximum surtax is misleading. We believe taxable income serves as a better gauge of what to expect."

CATCAP SURTAX IN PERSPECTIVE

Taxable Income	Federal Income Tax	Surtax 1989	Surtax 1990
$1,500	$ 150	$ 22.50	$ 37.50
5,000	750	112.50	187.50
10,000	1,500	225.00	375.00
15,000	2,250	337.50	562.50
20,000	3,000	450.00	750.00
25,000	3,750	562.50	937.50
30,000	4,533	675.00	1,125.00
35,000	5,933	877.50	1,462.50
40,000	7,333	1,080.00	1,700.00
45,000	8,733	1,305.00	1,700.00
50,000	10,133	1,507.50	1,700.00
52,400	10,805	1,600.00	1,700.00

In 1989, the maximum surtax is $800 for individual and $1600 for a couple filing jointly. In 1990, the maximum surtax is $850 for an individual and $1750 for a couple filing a joint return.

Regarding the Medicare Part B Monthly Premium deducted from your Social Security Check, during 1988 the per person deduction was $24.80. The per person increases in PL 100-360 are 1989 increase $4; 1990 increase 4.90; 1991 increase $5.46; 1992 increase $6.75 and 1993 increase $7.18. In additionthe law states should there be a shortfall an increase may be made. There is also a Prescription Drug monthly Premium deduction from your Social Security. The amount will be 1991 deduction to be $1.94; 1992 deduction $2.45; and, 1993 deduction $3.02.

In the CONGRESSIONAL RECORD No. 11 dated August 4, 1988 the HON Fortney H. (Pete) Stark stated, "Requiring all State and local government employees to pay the Medicare portion of the payroll tax could contribute about $2 billion a year to the costs of long term care. Finally, beneficiaries payments could be further increased although, following the increase for Medicare catastrophic coverage, it will already be more than $40 a month in 1993." "Since a comprehensive long-term care program might cost up to $50 billion a year, benefits may have to be phased-in. We have, of course, begun this process by adding over a billion dollars a year in new long-term care benefits in the Medicare catastrophic program."

In the Chicago Tribune article were the comments, Representative Dan Rostenkowski, D-ILL, chairman of the House Ways & Means Committee, and a prime sponsor of the catastrophic, legislation isn't budging. "If we revisit it, we'll repeal it." "And if we repeal it, it will be a big set back for health care, creating a big problem forever in enacting any health-benefit programs." "The people who are going to benefit from this are going to have to swallow and accept it," Rostenkowski said. "The elderly really have been big winners in the last 25 years" said Rostenkowski.

In an article written by Martin Tolchin, New York Times, regarding comments by Representative Fortney H. (Pete) Stark, a California Democrat who, as chairman of the Health Subcommittee of the Ways and Means Committee was one of the architects of the legislation said, "Some seniors just take the attitude that they should get these benefits and pay nothing."

An article written by Robert A. Rosenblatt for the Times stated, REP Pete Stark (D-Oakland) chairman of the House Ways and Means Committee on health which prepared this bill. Stark, "What do seniors want me to do, he asked, Kick up the taxes on working people? If I start taxing them 2% or 3% more and give them no benefits while providing more benefits for seniors, it will start a class war." Stark thinks many of the protesters are simply selfish. When he addressed a group of retirees in Woodland Hills, he said, they booed, they yelled, and they screamed. Most of them feel their richness is a result of some kind of superior genetic background and anybody who is poor should suffer the consequences." For most people, Stark insisted, "the Medicare expansion is a hell of a bargain". The chief Senate sponsor, Finance Committee Chairman Lloyd Bentsen (D-Tex) agrees. Bentsen stated, "The new law will provide peace of mind to millions of older Americans and their friends and relatives," it doesn't make sense to talk about changing the law before it even goes into effect." "Yes, its true that only those who benefit form this new catastrophic Medicare insurance will pay for it. Its also true that those who don't develop a costly illness won't receive any benefits, just like people with fire insurance don't get benefits if their house doesn't burn down."

In The Hayward Daily Review, dated January 12, 1989 in an article by Senator Bentsen, Washington (AP) - Blaming wealthy retirees for most of the complaints, the chairman of the Senate Finance Committee said, Wednesday, he anticipates no changes in a new tax on older Americans that pays for protection against costs of catastrophic illness. "There's a vocal minority sounding off" about the the tax," Sen Lloyd Bentsen D-Texas told reporters adding, the outcry will subside once the details of the program, which took effect Jan 1, are better known." "Mail and phone calls are coming chiefly from "wealthy people" who want it (cost of the catastrophic protection) to be more heavily subsidized by taxpayers in general, " he said.

In an article in the Hayward Daily Review dated January 16, 1989 Congressman Fortney H. (Pete) Stark is quoted as stating, "There is no free lunch in this country." Stark said, Stark said, "the law was thoroughly examined for two years. He compared it to fire insurance, noting that few people collect on such policies, but almost everyone needs coverage because they dont know when disaster could unexpectedly add them to the unlucky minority." " Stark calls the law, "one of the best things ever to happen to America's elderly. Stark, says "the law's critics are either misinformed or selfish, and he vowed to block any attempts to repeal it or delay its implementation."

In a Letter to the Editor dated February 10, 1989, a letter from Fortney H. (Pete) Stark, Congressman 9th District was printed. Quotes from this letter include the following, "Although no one has objected to giving seniors this protection, some object to the way it is paid for. The program is completely funded by its beneficiaries. In addition to a flat monthly rate that all seniors will pay, higher income seniors will pay a surcharge based on their income tax. It is this surcharge that is regarded as unfair," as recent letters have pointed out.

In another article by Robert A. Rosenblatt, Times Newspaper, Stark is quoted, "Everyone who has to pay a nickel complains," Stark said. "I remember my parents complained when they had to start paying Social Security taxes. Now my mother doesn't say a peep unless the checks are late."

In most of the quotes I have written is the continued repetition of the phrase, "the supplemental surtax is only being paid by the afflent wealthy retired members of the public who are complaining because they want a free ride." and "The retired elderly people paying the surtax are the people who will be the beneficiaries." We all know both of these statements are untrue but, lets assume this is a new tax concept that will be applied in the future.

Under this new tax concept, only the parents with children in school will pay the entire school tax, only farmers who who receive farm subsidies will pay the farm subsidy tax and, only those people who ride public transportation will pay transportation taxes. If these comments are absurd, then so is the fact the Congress selected the retired Middle Class elderly age 65+ with moderate taxable income of $150+ to apply the Catastrophic Health Care tax to.

I have read several excellent, many paged articles on the Catastrophic Health Care Law sent to me, that give a complete analysis of the benefits, costs, deceptions and the inequities. These articles were written by: COL John Roscoe USMC (Ret) Phd; LCOL Robert E. Blake USA (Ret) and, MAJ Morris Cleland USAF (Ret). I hope to obtain funding to make copies for distribution and therefore I have not duplicated or gone into a discussion of their work. My congratulations to the named officers for their fine work.

In conclusion, I hope the information provided gives you some areas to think about in your effort to amend the funding provision of the CATCAP Law PL 100-360 and, after a bill has been introduced in Congress that a majority of our members agree to support, we all will do all we can to have this legislation passed and signed by the President.

John M Gabel
John M. Gabel
COL USA (Ret)
Coordinator, CAL-TROA Committee of 45

3659 Monterey Blvd.
Oakland, CA. 94619
April 20, 1989

Margret K. Straw, Ph.D.
Research Associate, Research & Data Resources
American Association of Retired Persons
1909 K. Street
Washington, D.C. 20049

Dear Ms Straw:

I have received your report, "Opinions of Americans Age 45 and Over on the Medicare Catastrophic Coverage Act" and, I have made a very exacting and comprehensive study of the survey and, I will give you my findings.

It is a beautifully written and goes into all of the aspects of information you are obviously trying to substantiate for Mr Horace B. Deets, Executive Director AARP which was, "Support for Medicare Catastrophic Coverage Act is very strong."

For your information, never have I seen a survey that I consider to be more inaccurate and less valid then this one. The shocking and appalling thing that must be recognized is, due to your grossly inaccurate survey, powerful members of the United States Senate and the US House of Representatives are quoting the results of your survey as fact, that the elderly Medicare elgible support the Catastrophic Health Care Law PL 100-360. In my opinion, this cannot be further from the truth. I have spoken to assembled chapter AARP groups of three chapters in the San Francisco area and, todate, I have not found a person who supports PL 100-360.

The survey, by telephone, conducted by Hamilton, Frederick & Schneiders for the American Association of Retired Persons was a random sample of 1750 Americans age 45 and over who were surveyed between December 2 and December 18, 1988. The four questions asked and nebulous answers are discussed on page after page of your report. The four questions were:

a. This program does not add to the federal deficit.

b. Medicare enrollees - those people who are elgible to receive benefits - will pay the entire costs of the program.

c. All Medicare enrollees will pay a $4 a month basic premium for catastrophic care insurance.

d. Everyone elgible for Medicare who pays more than $150 in federal taxes will pay (a separate, supplemental) an extra premium based on the amount they owe.

I cannot express my outrage, in your using a question worded, like the wording in question (a). Who would oppose this question. No American wants to have the Federal deficit increased. With this question, you have already obtained a 25% positive result in your survey.

Question (b) simply is not true!!! In asking this question, worded as it is, without informing the person being surveyed of all the detailed facts, you simply obtain invalid results.

The facts about who pays the costs of Catastrophic Health Care program and, who receives the benefits are extremely complex and well hidden in the pages of PL 100-360 by members of the US Congress who wrote the law. Based on the information in your report, the people being surveyed, by telephone, did not have all the necessary information to give a factual response.

The true facts about who pays the costs and who receives the benefits are, Part B Medicare is paid by all Social Security recipients through a deduction made from their Social Security checks each month. The Supplemental Surtax for Part A of the Catastrophic Health Care Law is based on the (very limited) information you give in your question (d) but, it goes much further then you indicate. Now, who receives the benefits from the 30.7 Billion dollar (Congressional Budget Office figures), 40% of the Medicare elgible will pay the Supplemental Surtax, while the remaining 60%, certain disabled under the age of 65, Medicaid recipients and, AIDS victims will receive benefits without payment. Was this information given to the people answering the survey questions??

Question (c), totally inadequate to obtain a meaningful response. True only in the fact the Medicare enrollee will have $4 deducted from their Social Security check in 1989 for the monthly payment of Catastrophic Health Care. You did not inform the people being surveyed, each year this amount would be increased. In 1990 the monthly deduction will be $4.90; the monthly deduction in 1991 will be $5.46 plus $1.94 drugs; 1992 the deduction will be increased to $6.75 plus $2.45 for drugs; 1993 the deduction will be $7.18 plus $3.02 for drugs. At this time 1993 the individual monthly deduction from the Social Security check for the Catastrophic Health Care will be $122.40. The law states, this amount can be further increased by one percentage point per year based on the program costs.

Question (d), again totally inadequate information to obtain a meaningful response. Does not discuss the fact only 40% of the Medicare elgible would be paying the surtaxes or the fact the maximum for one person for 1989 is $800 or for two people is $1600 or that the tax rate is 15% for 1989; 25% for 1990; 26% for 1991; 27% for 1992 and; 28% for 1993 which puts the elderly retired on a higher tax rate than is being paid by millionaire members of our society. I could go much further in detail but, I am sending you Economic Report No. 47 from the Institute for Research on the Economics of Taxation dated February 24, 1989 which will give you additional factual information

With your Ph.D. Ms Straw, I am absolutely amazed you would sign your name to such an obviously erroneous report as this.

I am sending you several items to demonstrate to you there is a great deal more information about PL 100-360 known by the public then you give us credit for.

Sincerly yours

John M Gabel

John M. Gabel, AARP Member No. 13088324

Encl: 1.General Council Resolution, CSEA., Catastrophic Health Care Act, adopted 10/10/8
2.IRET Economic Report No. 47 dated February 24, 1989
3.Legislative News, CSEA, dated March 15, 1989
4.CAL-TROA Legislative News UpDate, dated April 18, 1989

3659 Monterey Blvd.
Oakland, CA. 94619
May 24, 1989

The Honorable Lloyd Bentsen
United States Senate
Washington, D.C. 20510

Dear Senator Bentsen:

I have received information that your committee, the Senate Finance Committee, plans to revisit HR #2470 the Catastrophic Health Care Law PL 100-360, on June 1, 1989. If this is true may I suggest some areas to be considered in your revisit.

1. Please consider the fact that approximately 70% of the retired elderly already have Health Care Plans with Catastrophic Coverage and, as a result of Public Law 100-360 are being forced to pay Supplemental Surtaxes and Medicare Premiums for which they will receive absolutely no benefits. This group includes retired members of the Armed Forces who were told they would be entitled to Hospital and Medical treatment for the rest of their life for the retiree and spouse on retirement. Retired federal civil service employees paid for their retirement health plans during their working years. It is true that the Congress gave former Governmental Retirees a special reduction ($6000 single or $9000 married filing jointly) but after the deduction of Social Security, the amount of deduction is miniscule. State, Local Government and, Teachers retirement include Health Care Plans that were negotiated by giving up other benefits and wages. Retired members of Unions participated in Collective Bargaining and received their Health Plan coverage at the loss of other benefits and wages. Now, with PL 100-360, the Catastrophic Health Care Law, this large group of elderly middle class retired who suffered through the Great Depression, served this nation in World War II and, in the case of retired members of the Armed Forces, also served in Korean War and in many cases, the Vietnam War, are being forced to pay the Supplemental Surtaxes and increased Medicare Part A Premiums, for which they will receive no benefits.

2. Please also consider the very substantial increase in the Part A Medicare Premium that will reach $122.40 per person in 1993 and, the Part B Medicare Supplemental Surcharge that will progressively increase from 15% in 1989; 25% in 1990; 26% in 1991; 27% in 1992; and, 28% in 1993. These tax increases will require the middle class elderly, Medicare elgible with Federal taxes of $150 to pay a higher tax rate then is required of millionaires. Further, with the great Tax Restructuring several years ago, the United States Congress and President Reagan promised, the top US Tax Rate would be 28%. Obviously, the Restructured Tax Law does not include the middle class elderly who are Medicare elgible.

3. Please, carefully reread this law regarding the fact, PL 100-360 requires approximately 40% of the elderly Medicare elgible with Federal Income Taxes of $150+ to pay a supplemental surtax of 15%, with a maximum of $800 for the year of 1989, while 60% of Medicare beneficiaries, certain disabled under Medicare, under the age of 65, Medicaid beneficiaries and, AIDS victims receive benefits of the Catastrophic Health Care Law without payment of a supplemental surtax. Does the Senate Finance Committee really believe it is fair that only 40% of Medicare elgible with Federal Income Taxes of $150+ should be the the only members of the American public paying the supplemental surtax for all the people listed as beneficiaries of the Catastrophic Health Care Law??!!

4. Please consider the fact, that traditional social insurance programs, Social Security and Medicare spread the cost among employers, employees, the self employed and beneficiaries in the case of Medicare. With the new concept, under the Catastrophic Health Care Law, where Congressional supporters have stated, "Yes, its true that only those who benefit from the new Catastrophic Medicare Insurance will pay for it". This statement has been made by several members of Congress and is a gross fabrication as we know most of the beneficiaries do not pay for it. Let us consider this new concept in writing future tax laws, only people with children in school will have to pay school taxes; only veterans will be taxed for Veterans Hospitals; only farmers will be taxed for farm subsidies; only people who ride public transportation will pay taxes to subsidize public transportation; I could go on and on with this absurd concept, think about it.

5. Please consider the fact, under PL 100-360, the Catastrophic Health Care Law, as it is presently written, the law will benefit only one percent of the beneficiaries who are hospitalized more then 60 days annually, and will benefit only the seven percent who exceed $1,370 out-of-pocket deduction for physicians' services, and will benefit only seventeen percent by its partial coverage for prescription drugs. Is this truly a Catastrophic Health Care coverage??!!

6. Please consider the fact, Public Law 100-360, regardless of its title, Catastrophic Health Care Law does not provide protection for the elderly from the impoverishing costs of long-term home or custodial care as the title implies.

7. Please consider the gross unfairness to the elderly by including in this law the statement, "Not treated as a Medical Expense - For purposes of Section 213, the supplemental premium (Surtax) imposed by this section in any taxable year shall not be treated as an expense paid for Medical care." This is a further discrimination against the elderly age 65+ who are being required to pay the supplemental surtaxes because, other members of the public who purchase Medigap policies are allowed to take a tax deduction for their expense paid.

I have listed seven areas that I would like to have you consider in your revisit of the law. On completion of your revisit, I would appreciate an answer to my suggested areas and, I would like to have you notify the National Media of the Senate Finance Committee decisions on this law.

I would like to have your Senate Finance Committee find in their revisit, that Public Law as originally written was not given adequate study and, you now consider the law to be setting a dangerous precident by taxing approximately 40% of the elderly to pay for all the Catastrophic Health Care Law benefits for all the elderly, the disabled of all ages and, Medicaid and AIDS victims.

Last, I would like the Senate Finance Committee to agree to support Senator John McCain S. 335 to delay implementation of PL 100-360 for one year except for the long term hospitalization and spousal impoverishment and, to hold open hearings for amending the law,

Sincerely yours

John M. Gabel

cc: Senator Alan Cranston
Representative Fortney P. Stark
Representative Ronald Dellums

LAURA WILSON,
Hearing Administrator,
Senate Dirksen Office Building,
Washington, DC.

Dear Ma'am: Please see that this letter gets to those individuals who can repeal or amend that disastrous Medicare Catastrophic Coverage Act (MCAA: Public Law 100-360). It's a bad deal for so many retired individuals and those facing retirement.

As a retired U.S. Air Force officer, and now an employee of the California State legislature, I will have insurance to supplement Medicare as part of my retirement benefits. Like me, the majority of elderly people I know already have supplemental insurance. Like them, I resent being forced to pay higher taxes for unnecessary coverage—at higher tax rates than anyone else in the country.

MCAA is age discriminatory because it will shift a portion of the Nations's welfare burden from the general population to elderly taxpayers. An income tax levied against just one age group is not only unfair, it is unprecedented. I also believe MCAA will cause much of the higher taxation of the elderly to pay for other Federal spending.

MCAA will raise the total cost of comprehensive health insurance. I am convinced it will cost me more than I can expect to receive in benefits. I am also convinced it would be better to have financial protection against long-term nursing home costs than the benefits in the new act.

I am a member of the American Association of Retired Persons (AARP), but I do not agree with its position on MCAA.

My wife and I have worked very hard to be able to take care of ourselves. We've planned responsibly to live on fixed incomes in our later years. MCAA is not fair and we are very upset about it. This is the first time we've felt so strongly about an issue to write you.

Please don't let us down. Repeal or amend the Medicare Catastrophic Coverage Act.

Sincerely,

ARN J. GITTLEMAN.

June 15, 1989

I DONT CARE TO PARTICIPATE IN THE CATASTROPHIC COVERAGE ACT, BECAUSE WE ARE BLACK AND THROUGHOUT THE YEARS, WE HAVE EXPERIENCED THAT BEING BLACK, AND HAVE ENCOUNTERED RACIAL TYPE THINGS IN HOSPITALS, ESPECIALLY THE MOMENT WE SHOW OUR FACE IN THE HOSPITAL. WE ARE CLASSIFIED AS FOLLOWED: WHEN WE WALK INTO A HOSPITAL " IF YOU SEE A BLACK YOU SEE ONE, AND IF YOU SEE ONE YOU SEE THEM ALL AND THE PROGNOSIS AND DIAGNOSIS IS ALREADY MADE UP OR THEY DONT LIKE TO WORK. NOR DO I WANT TO PAY INTO A SYSTEM THAT WILL TREAT US WRONG BECAUSE WE ARE BLACK, NOR DO I WANT TO PAY INTO THE SYSTEM FOR THE LAZY. I HAVE WORKED MOST OF MY LIFE. I,M 65 and my wife is 55.

INCIDENT: I HAD A STY IN MY LT EYE. THIS VIETNAMESE SAW THAT I WAS BLACK, TOLD ME TO WASH IT OUT WITH BABY SHAMPOO, I WANTED SOME EYE DROPS. HE TREATED ME LIKE DIRT. SO I HAD TO GO AND SEE ANOTHER DOCTOR (AMERICAN) AND WAS GIVEN ISOPTOCETAMIDE EYE DROPS. I SPENT TIME OVERSEAS IN VIETNAN 1962 AND I CAN SEE THIS VIETNAMESE IN UNIFORM.

INCOME: Airforce: $500 (RET)

State: $1600 After deductions

OUTGOING: BILLS: PER MONTH** $1400.

MEMO: I HAVE MEDIAL COVERAGE THROUGH MY RETIREMENT: (KAISER)
I HAVE FOUNDATION HEALTH $30 PER MONTH FOR THE FAMILY.
I HAVE AARP $36 PER MONTH.

I DONT NEED ADDITIONAL MEDICAL COVERAGE SUCH AS CATASTROPHIC COVERAGE.

AFTER MY DAUGHTER LEAVE OUR HOME, IF WE HAVE AN CATASTROPIC MEDICAL PROBLEM, MY WIFE AND I HAVE AGREED TO TAKE CYANDE PILLS OR TABLETS.

P.S. FROM MY SOCIAL SECURITY, I SEND MONEY TO OUR OLDEST DAUGHTER, SHE ATTENDS STOCKHOLM UNIVERSITY.

SOCIAL SECURITY: 281-28-0510

THANKS, MR MRS JAMES H. GRAHAM JR., RET AF SSGT
1848 43rd Street
Sacramento, California 95819

(916) 452-1551

Senator **Lloyd Bentsen**,
Chairman, Senate Finance Committee,
Washington, DC.

Dear Senator Bentsen: I am one of the senior citizens who are upset the Medicare Catastrophic Act of 1988.

As a California State Retiree, my insurance coverage is sufficient.

As a retiree with limited resources, the Medicare Catastrophic Act is indeed a catastrophe. I have always endeavored to he independent and resent efforts, though well intentioned, that increasingly put my independence in jeopardy.

Please, do what you can to amend this Act.

Respectfully,

NANCY GRAHAM.

STATEMENT OF THE GRAY PANTHERS OF LONG BEACH

Dear Ms. Wilcox: As Administrator of the present hearings on the funding of the Catastrophic Medicare Act of 1988, the Gray Panthers of Long Beach hereby submit a proposal to you for funding the Act which would replace the present surtax funding.

Last year, I was one of two delegates from our Gray Panther chapter who attended the September convention of the National Council of Senior Citizens in Las Vegas. We remember that on the very day hundreds of us were telephoning our representatives to support the Pepper Long Term Home Health Care bill the Catastrophic Medicare bill was hastily passed. The reason seems to be that the Reagan Administration and Congress did not want the wealthy to pay their share of health bills. The Pepper bill would have been financed by extending Social Security payroll taxes to the entire salary of those earning more than $48,000 a year. Since everyone earning below $48,000 pays payroll taxes on their entire salary it is only fair that all employees should do the same.

Our chapter of the Gray Panthers is now proposing that the 1.45% of the 7% payroll tax now going to Medicare be extended to the entire salaries of those earning more than $48,000.

Please see that the hearings consider this fair method of funding the Catastrophic Medicare Act in place of the present surtax which forsakes the social insurance policy of Social Security and would put an unfair burden on middle class seniors.

Sincerely,

MARGARET BLAIR, CO-CHAIR.

Attachment.

STATEMENT OF GRAY PANTHERS

SENATOR BENTSEN: Gray Panthers commend your efforts to improve the recently enacted catastrophic health care legislation.

Gray Panthers is an intergenerational organization of 70,000 members and supporters working on issues involving social change and economic justice. Our short-term goal is to monitor and improve the present health care system; however, our ultimate goal is to achieve a national health care system which would provide quality health care to all Americans as a basic human right. The inadequacies and inequities of the present system have all too often resulted in denial of full access to needed health care services to millions of Americans and financial hardship for even more. Long term care for those suffering from serious and protracted illnesses is especially inadequate and costly.

When Gray Panthers met in Convention last November, consideration of health issues was a topic of major concern. The newly enacted Catastrophic Protection Act was discussed and the following concerns were raised:

- Long term care, the real catastrophic health care need is not provided;
- The principle of social insurance is abandoned when the entire financing burden is placed on those receiving benefits;
- The needs of the 40 million Americans who are outside the health care system are not addressed by this legislation.

As a result, delegates to the Convention passed the following resolution:

> Be it resolved that Gray Panthers call upon Congress to develop a financing plan that is faithful to the social insurance principal of social security

> and report such a plan within 90 days after the 101st Congress is convened; and
>
> Be it further resolved that Congress enact the long-term care legislation that Congressman Claude Pepper proposed in the 100th Congress—H.R. 2263 to provide home health care to chronically ill persons of all ages.

More recently, Gray Panthers have also gone on record in support of legislation introduced by Senators Levin and Harkin and Representative Bonior as a progressive alternate way of financing Catastrophic Illness Premiums. While we view this alternate financing mechanism as a needed amendment, it by no means addresses the serious flaws which counter the very intent of Congress in moving to enact significant health care legislation by addressing real catastrophes that occur everyday in our society to Americans of all ages.

Catastrophic health care protection must provide long-term care protection to and meet the needs of people of all ages, not for just those who qualify for Medicare.

We urge you to continue the hearings process by calling upon your Congressional colleagues to plan additional hearings to solicit the views of their constituents on this catastrophic health legislation. We especially urge you to use your leadership to bring about improvements in this law.

Senator Lloyd Bentsen,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen: I wish to register a strong complaint *against* the Medicare Catastrophic Act of 1988. If I am obligated to the Act, shall be unable to pay my annual tax to IRS!!!

Davidina Heath.

Senator Lloyd Bentsen,
Chairman, Senate Committee on Finance,
Senate Dirksen Office Building,
Washington, DC.

Subject: Eliminate Medicare Catastrophic Act Surtax

Dear Senator Bentsen:

1. I respectfully urge your *support for the elimination of the SURTAX* and your continued efforts to finding a more equitable solution to the financing of the Medicare Catastrophic Act.

> NOTE: It seems to me that everyone will someday benefit from this, therefore why isn't everyone contributing to it.

2. It also seems that the people who need it the least (or not at all) are the ones who are required to pay for the other 60%.

> NOTE: I worked hard all my life and made many sacrifices along the way to provide for my retirement years and not be a burden on my family or community. It simply is *not fair* to put a SURTAX of any kind on any group.

Sincerely,

Faye I. Heidenreich.

Dear Senator Bentsen: My husband and I are senior citizens. Before our marriage both of us worked to help finance our own college educations. We both served in World War Two raised and educated two children, gave time and money to church and charity and took part in community service. We purchased medical plans through the company my husband worked for and lived prudently so that we were able to meet medical emergencies when they came up. We voted in all elections, paid our taxes and put aside money for our retirement. In other words we were good citizens.

Our reward for being good citizens is a new discriminatory tax on our fixed income which will have to come out of the reserves we put aside for a few pleasures in our old age. We have always paid our fair share of taxes but strongly object to the manner of financing the new Medicare Catastrophic Act which places a grossly unfair burden on a portion of a certain age group. We have no objection to paying our fair share but there must be a more equitable way of financing this "Act." By the way we are members of AARP but they do not speak for us.

Yours truly,

Roberta and Hary Heidenreich.

Senator Lloyd Bentsen,
Chairman, Senate Finance Committee,
Senate Dirksen Office Bldg.
Washington, DC.

Dear Senator Bentsen: We object to the Medicare Catastrophic Coverage Act of 1988.

In our area the amount of tax we will be forced to pay will not cover *one* day of hospitalization.

In the infinite wisdom of the Finance Committee there must and has to be a better method of caring for Catastrophic Coverage.

Sincerely,

William and Priscilla Herbert.

Senator Lloyd Bentsen,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

RE: Medicare Catastrophic Act, 1988

Dear Senator: As a Senior Citizen I am astounded that the Senate passed the Medicare Catastrophic Act, which will cost my wife and I $1,600 this year, in addition to the other expense I already pay Medicare, and the costs of the Supplemental policy I have to carry to supplement MEDICARE!

This is nothing more than tax upon tax. In my opinion this Bill deprives me of my property without due process of law, in other words, it is unconstitutional.

I would ask that you give consideration to the middle class American and his share of the taxes.

Very truly yours,

Daniel J. Higgins.

Dear Senator Lloyd Bentsen,
Chairman, Senate Finance Committee,
Washington, DC.

I am 68 years of age, a survivor of World War 2, three and one-half years as a P.O.W. of the Japanese and the multiple disabilities which have resulted in my not being able to work anymore.

Since the Good lord has seen fit to bring me through all that, I try not to complain, but this time I feel that a major complaint is not only justified but would be a drastic and foolish over-sight if I did not write this letter of complaint arid censure.

Specifically, I refer to the infamous MEDICARE CATASTROPHIC ACT OF 1988. This Act, which came from the Committee which you chaired is one of the most outrageous, unjust and discriminatory possible; not only in my opinion but that OF EVERY PERSON OVER 65 WITH WHOM I've discussed the ACT.

You and your Committee have written an ACT which singles out a small portion of the elderly arid imposes upon them a noxious, unjust, highly discriminatory and totally disastrous surtax upon the tax(es) we already must pay the IRS.

No other segment of the population is cruelly singled out for this odorous action.

You, Sir, and your Committee, are still able to right this grievous, cruel and outrageous ACT. PLEASE DO SO!!! It not only would right a horrible wrong, but may yet help you and your Committee avoid an overwhelming back-lash of public opinion and retaliation not only in the media but also the polls.

I implore you, as one Christian to another, to rewrite the ACT so that ALL the population are treated as one and the same, as they should, before it is too late.

Sincerely,

Mr. and Mrs. Frank W. Hoover.

Senator **Lloyd Bentsen**,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen: The Medicare Catastrophic Act is the worst rip-off of the elderly that has ever been enacted. It must be changed.

Most of the retirees have this coverage included in their ret retirement programs and at a very reasonable premium. My company provides it for approximately $140 a year as compared to the more than $500 a year you are adding to my taxes.

It is estimated only about 2% of the elderly will utilize the coverages, in spite of the phony figures put out by the AARP. They have a vested interest in the program in that they will make big money from the drug portion. Few of us stay in the hospital for any length of time. We are patched up and sent home or we die there in a short length of time.

The major recipients of the program will be the homosexuals and drug users who have aids. I do not like being singled out to pay for their care.

It is not fair that we who are in the moderate income group should have the highest tax rate in the nation. This unfair tax, along with the tax on our Social Security income, has doubled my income tax in the last few years while most people enjoyed tax cuts.

I feel my government has broken faith with the elderly. We are paying for something the majority of us do not want or need. The argument that we should be taxed because we will be the beneficiaries of the program is not valid. If so, should we not be exempt from any tax for education if we have no children in school?

It appears most of the funds will be used to make the deficit appear lower so congress can spend more money to buy votes. The program should be scrapped. At the very least the financing should be revised so that everyone shares the burden.

The elderly deserve and should get a better deal than this.

Yours truly,

C.E. Hornor.

IRET ECONOMIC REPORT

February 24, 1989 NO. 47

THE INSURANCE VALUE OF MEDICARE'S CATASTROPHIC BENEFITS

Last summer many hailed the passage of the "Medicare Catastrophic Coverage Act of 1988" (Public Law 100-360) as landmark legislation which would protect the elderly against major out-of-pocket medical expenses. The Congress believed that this action, which represents the largest expansion of Medicare since its inception almost 25 years ago, would be both popular and much appreciated.

Beginning last fall, and continuing until the present time, however, actual public reaction to the Catastrophic Coverage Act has been negative and vociferous. Grass roots organizations have sprouted up across the country, deluging Congressional offices with phone calls, angry letters and petitions.[1] To a large extent, the basis for these objections is the requirement that the benefits be paid for by a monthly "premium" on all Medicare enrollees and by a new tax on Medicare-eligible taxpayers. As more Medicare enrollees, particularly the elderly, become aware of their potential added tax burden, they are questioning whether this new "protection" is worth the cost.

Key sponsors of the Act, however, continue to maintain that it is good legislation. According to Senator Lloyd Bentsen, "It's the best buy in town . . . . there's nothing in the private sector that offers what it offers at those prices." Ways and Means Chairman Dan Rostenkowski echoes those sentiments claiming, "The benefits are worth the costs."[2] Senator Bentsen also says, "A very vocal minority is sounding off . . . . What you have is wealthier people not wanting to pay the additional premium and wanting it to be more heavily subsidized by other taxpayers."[3]

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[1] One Las Vegas group, the new Seniors Coalition Against the Catastrophic Act, has collected over 100,000 signatures to repeal the Act. See Jane Bryant Quinn, "Senior Citizens Mobilizing Against the Catastrophic Health Costs Act," *The Washington Post*, January 23, 1989.

[2] Spencer Rich, "Catastrophic Insurance Attacked as Unfair Tax," *The Washington Post*, January 15, 1989, p. A-3.

[3] Helen Dewar, "Bentsen Opposes Rollback of Medicare Surcharges," *The Washington Post*, January 12, 1989, p. A-5.

Institute for Research on the Economics of Taxation

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1331 Pennsylvania Ave., N.W., Suite 515, Washington, D.C. 20004 (202) 347-9570

IRET BRIEFING February 24, 1989

The Insurance Value Of Medicare's Catastrophic Benefits

by Aldona Robbins and Gary Robbins

Economic Report # 47

- The Medicare Catastrophic Coverage Act is a bad deal for millions of the elderly. It will:
  - -- cost the elderly more, on average, than they can expect to receive in benefits,
  - -- shift a portion of the nation's welfare burden from general taxpayers to elderly taxpayers,
  - -- use much of the higher taxation of the elderly to pay for other federal spending,
  - -- raise the total cost of comprehensive health insurance.
- Under the Catastrophic Coverage Act, all Part B Medicare enrollees must pay a flat premium, and all taxpayers eligible for Medicare, whether enrolled or not, must pay an income tax surcharge.
  - -- The premium in 1989 is $48 per month per enrollee ($96 per couple) for Part B catastrophic coverage, rising to $122.40 in 1993.
  - -- The surtax in 1989 is $22.50 for every $150 of income tax liability, a surtax rate of 15 percent, up to a maximum surtax of $800 ($1,600 per couple). The surtax rate will rise to 28 percent by 1993 with a maximum surtax of $1,050 ($2,100 per couple).
  - -- A retired couple with an average social security benefit of $11,000 and with $25,000 in other income would pay a surtax of $329 in 1989; in 1993 this couple would pay $728.
- In 1989, no less than 46.1 percent of the elderly will pay some surtax, and 8.6 percent will pay the maximum. In 1993, 46.5 percent of the elderly will pay some surtax, and 21.1 percent will pay the maximum.
- For these added taxes and premiums, elderly Medicare enrollees will receive an average of $46.57 in benefits in 1989. Most enrollees, however, will not have enough medical expenses to qualify for benefits; between roughly 17 and 31 percent of enrollees will receive all the payments. As additional benefits are phased in, the average "expected benefit" for elderly enrollees will increase to $273.47 per enrollee in 1993.

- Individually, many elderly will pay more into the system than they may expect to get back, on average, in benefits.

  -- In 1989, the $48 premium alone is larger than the average expected benefit for the elderly of $46.57. Among the elderly, only Medicaid enrollees, whose premium is paid by Medicaid, will have an expected gain from the Act.

  -- By 1993, as other benefits are phased in, more of the elderly will gain, but approximately 40 percent of the elderly will be paying enough surtax so that they will be net losers in terms of the Act.

- Counting premiums and surtaxes, the elderly as a group will pay $4.7 billion more in 1989 and $3.9 billion more in 1993 than they will receive in benefits.

- The Catastrophic Coverage Act is an income redistribution device in disguise.

  -- Upper- and middle-income Medicare-eligible taxpayers will subsidize lower-income catastrophic care recipients.

  -- Some Medicaid benefits, previously funded by general revenues, are now financed by Catastrophic Coverage Act revenues.

  -- Elderly enrollees will also help pay for the benefits received by disabled enrollees.

- Medicare enrollees as a whole will pay more in taxes and premiums than necessary to cover near term program costs. In 1989, collections will exceed catastrophic benefits and administrative costs by $4.2 billion.

- The Catastrophic Coverage Act will duplicate nearly two-thirds of the dollar amount of catastrophic benefits previously covered by Medigap policies. Because of the way the Act splits coverage between private insurance and Medicare, the Medigap insurers will be left with higher risk, resulting in more expensive insurance for Medicare enrollees seeking total coverage.

Table 4

CATASTROPHIC PREMIUMS AND TAXES PAID BY MEDICARE ENROLLEES

PREMIUM PER ENROLLEE

	1989	1990	1991	1992	1993
Monthly catastrophic	$4.00	$4.90	$5.46	$6.75	$7.18
Monthly drug	0.00	0.00	1.94	2.45	3.02
Monthly Total	$ 4.00	4.90	7.40	9.20	10.20
Annual catastrophic	$48.00	$58.80	$65.52	$81.00	$86.16
Annual drug	0.00	0.00	23.28	29.40	36.24
Annual Total	48.00	58.80	88.80	110.40	122.40

SUPPLEMENTAL SURTAX

Surtax rate	15%	25%	26%	27%	28%
Max. per enrollee	$800	$850	$900	$950	$1,050

As with the monthly premium, after 1993, the surtax rate and maximum tax will increase, based upon the growth in program costs. The increase in the surtax rate, however, is limited to one percentage point per year.

What Will Beneficiaries Pay?

The exact amount beneficiaries will have to pay to support the Catastrophic Coverage Act will depend upon their income level and tax filing status (e.g., single; married, filing jointly; married, filing separately). Table 5a lists the surtax that will be paid by a single retired worker and by a retired married couple from 1989 to 1993 with varying amounts of income. Both types of taxpayers receive the average social security benefit in 1989, which is $6,300 for a retired worker and $11,000 for a married couple, and take the standard deduction. Their social security benefits, as well other income, are assumed to increase by the annual rate of inflation.[14] (The Appendix contains similar tables showing tax amounts for single and married taxpayers with low and high social security benefits.)

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[14] We assumed inflation would increase by the amounts projected in the Fiscal Year 1990 budget, or roughly 3 percent a year. See Executive Office of the President, Office of Management and Budget, *Budget of the United States Government, Fiscal Year 1990*, p. 3-14.

Table 5a

CATASTROPHIC TAXES PAID BY MEDICARE ENROLLEES

Surtax Paid by a Single Retired Worker with Average Social Security Benefits

	1989	1990	1991	1992	1993
SOCIAL SECURITY BENEFIT	$6,300	$6,540	$6,745	$6,930	$7,080
OTHER INCOME[*]					
$0	$0	$0	$0	$0	$0
$7,000	$26	$44	$47	$49	$47
$8,000	$48	$83	$88	$93	$94
$9,000	$71	$122	$130	$138	$141
$10,000	$93	$160	$172	$182	$188
$12,500	$150	$258	$276	$293	$306
$15,000	$206	$355	$381	$405	$424
$17,500	$262	$452	$485	$516	$542
$20,000	$318	$550	$590	$637	$682
$24,100	$452	$816	$900	$950	$1,050
$30,000	$785	$850	$900	$950	$1,050
$30,400	$800	$850	$900	$950	$1,050

Surtax Paid by a Married Couple with Average Social Security Benefits

	1989	1990	1991	1992	1993
SOCIAL SECURITY BENEFIT	$11,000	$11,415	$11,780	$12,095	$12,360
OTHER INCOME[*]					
$0	$0	$0	$0	$0	$0
$11,500	$25	$41	$45	$42	$43
$13,000	$59	$99	$108	$109	$114
$15,000	$104	$177	$192	$198	$208
$17,500	$160	$274	$296	$310	$326
$20,000	$216	$372	$400	$421	$444
$25,000	$329	$566	$622	$675	$728
$30,000	$480	$852	$935	$1,009	$1,082
$35,000	$649	$1,143	$1,249	$1,334	$1,411
$40,000	$871	$1,509	$1,623	$1,714	$1,799
$43,400	$1,013	$1,700	$1,800	$1,900	$2,100
$50,000	$1,291	$1,700	$1,800	$1,900	$2,100
$55,000	$1,501	$1,700	$1,800	$1,900	$2,100
$57,400	$1,600	$1,700	$1,800	$1,900	$2,100

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[*] Other income is shown at 1989 levels, which increase at the annual rate of inflation assumed in the Fiscal Year 1990 Budget, about 3 percent a year.

Table 5b

CATASTROPHIC PREMIUMS AND TAXES PAID BY MEDICARE ENROLLEES

Premium & Surtax Paid by a Single Retired Worker with Average Social Security Benefits

	1989	1990	1991	1992	1993
SOCIAL SECURITY BENEFIT	$6,300	$6,540	$6,745	$6,930	$7,080
OTHER INCOME*					
$0	$48	$59	$89	$110	$122
$7,000	$74	$102	$135	$159	$169
$8,000	$96	$141	$177	$203	$216
$9,000	$119	$180	$219	$248	$264
$10,000	$141	$219	$261	$293	$311
$12,500	$198	$317	$365	$404	$429
$15,000	$254	$414	$470	$515	$547
$17,500	$310	$511	$574	$627	$665
$20,000	$366	$608	$678	$747	$804
$24,100	$500	$875	$989	$1,060	$1,172
$30,000	$833	$909	$989	$1,060	$1,172
$30,400	$848	$909	$989	$1,060	$1,172

Premium & Surtax Paid by a Married Couple with Average Social Security Benefits

	1989	1990	1991	1992	1993
SOCIAL SECURITY BENEFIT	$11,000	$11,415	$11,780	$12,095	$12,360
OTHER INCOME*					
$0	$96	$118	$178	$221	$245
$11,500	$121	$159	$223	[illegible]	$288
$13,000	$155	$217	$286	[illegible]	$359
$15,000	$200	$295	$369	$419	$453
$17,500	$256	$392	$474	$530	$571
$20,000	$312	$489	$578	$642	$689
$25,000	$425	$684	$800	$896	$972
$30,000	$576	$969	$1,113	$1,230	$1,326
$35,000	$745	$1,261	$1,426	$1,555	$1,656
$40,000	$967	$1,627	$1,801	$1,935	$2,044
$43,400	$1,109	$1,818	$1,978	$2,121	$2,345
$50,000	$1,387	$1,818	$1,978	$2,121	$2,345
$55,000	$1,597	$1,818	$1,978	$2,121	$2,345
$57,400	$1,696	$1,818	$1,978	$2,121	$2,345

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* Other income is shown at 1989 levels, which increase at the annual rate of inflation assumed in the Fiscal Year 1990 Budget, about 3 percent a year.

STATEMENT OF THE INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS, BY ALFRED WHITFHEAD, PRESIDENT

Dear Senator Bentsen: On behalf of the International Association of Fire Fighters, AFL-CIO, CLC and its 177,000 members, I am submitting this statement of position on legislation to delay the implementation of the supplemental premium under the Medicare Catastrophic Coverage Act. I respectfully request that this statement be included in the record of the June 1, 1989 Finance Committee hearings.

The IAFF supports legislation to delay the effective date of implementation of the supplemental premium while alternative financing mechanisms are studied. Since the cost and revenue estimates for this program have varied widely, it appears that the high cost of participation for Medicare-eligible individuals may be unnecessary and unduly burdensome.

The IAFF believes that the funding mechanism for the program should follow the traditional approach of inter-generational financing together with a small premium, if necessary, to meet the actual costs of the program. This approach would go a long way toward reducing the burden of the cost of participation for the elderly.

A recent poll by the Wirthlin Group shows that 53% of retirees surveyed oppose the program in its current form with 39% strongly opposing the program. The survey further reveals that 65% of those questioned prefer a program which provides long-term home care as opposed to extended hospitalization and physician benefits.

This opposition stems not only from the high cost of participation in the program, but also from the fact that the benefits provided duplicate benefits which a majority of the nation's retirees already have as a result of participation in supplemental insurance plans. This is particularly true of fire fighters. Due to the hazardous nature of their occupation, our members contract cancer and heart disease at twice the rate of the general population and experience a much higher rate of disabling injuries than most other occupational groups. For this reason, fire fighters have spent years establishing retirement health benefit plans which reflect the needs and realities of the public safety professions. In most cases, retired fire fighters must pay for coverage under their retirement health plans.

At a minimum, in the event that revenues generated by the program will exceed costs, the supplemental premium must be reduced or eliminated expeditiously. The retired citizens of this country should not be expected to bear any unnecessary costs for the cause of creating the appearance of a smaller deficit.

In summary, I urge the Committee to take action to delay the implementation of the supplemental premium and conduct a complete review the program's financing mechanism.

[From the Sacramento Union, March 18, 1989]

MANY 'SINS' ARE RECOUNTED

I would like to thank Sens. Alan Cranston, Lloyd Bentsen, Rep. Dan Rostenkowski and the rest of their cohorts for pushing through the Medicare Catastrophic Coverage Act.

All we middle income retirees are so very grateful. We really don't deserve your help. God knows we have committed every sin in the book.

1. We are guilty of working hard to prepare for our retirement years.
2. We have never served a jail sentence.
3. We have paid our bills on or before the due date.
4. We have never dealt in drugs.
5. I'm ashamed to admit we haven't a parking ticket to our name. Shame, shame to be law abiding citizens.

You keep up the good work and before long you kind gentlemen will have most of us elderly on your welfare rolls. Now there's something for you to be proud of.

I have one little worry: where in the world will you get your money from when we are gone?

VELMA JANUARY,
Sacramento.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen: Although the Medicare Catastrophic Coverage Act has many inequities, I will concentrate on only one.

The funding mechanism is based on the philosophy that only those who stand to benefit will pay the costs. Factually, this is not true.

Many of us who have retired from military service will never derive any benefit from this coverage, yet we will pay.

Many of us have some form of medi-gap coverage for which we pay a premium. Unfortunately, CATCAP does not replace the coverage by my medi-gap insurance.

If the philosophy behind this act had been applied to past social programs, only those people with children in school would be paying the cost of public education . . . only people in agriculture would be providing funds for farm subsidies . . . etc.

Why not return to the prior system of Medicare Parts A and 9 and in addition create a Part C . . . encompassing the additional coverage provided under CATCAP . . . and make participation in Part C optional. Those who opt to participate will support the system. This would be an interim system while Congress explores the long range program of designing a system to provide complete medical care for ALL Americans.

Sincerely,

EARL VON KAENEL.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

RE: The Medicare Catastrophic Protection Act (HR2470)

Dear Mr. Bentsen: In connection with the hearings now taking place on the above-referenced subject I am resubmitting letters that I had previously written to my Congressional representative and your office outlining my feelings on this matter.

After exposure to reams of rhetoric on this subject over the last few months I am more than ever convinced that a grave injustice has been perpetrated with respect to the financing mechanism to pay the cost of this so-called "catastrophic protection."

The crux of this legislation is the inclusion under Medicare of economically distressed senior citizens who have no medical insurance protection and are otherwise ineligible for Medicare. This procedure becomes a matter of outright charity. So let us broaden the base to include the whole spectrum of taxpayers mandated to pay the cost of this welfare program, as is usual in the many other instances of government generosity. In my view, the law, as written, is an insufferable outrage.

Yours truly,

FRED E. KAUFFMAN.

Enclosures.

Hon. LLOYD BENTSEN,
Hart Senate Office Building,
Washington, DC.

Dear Mr. Bentsen: Attached is a letter I wrote to my congressional representative when publicity concerning this scam, labeled the "Medicare Catastrophic Protection Act" (HR 2470), began to emerge.

The letter I wrote still reflects my feelings regarding this law, in spite of the reams of propaganda published by AARP and its political supporters to justify this monstrous legislation.

Also enclosed is a recent clipping from the Sacramento Union newspaper which would generally reflect the thinking of most senior citizens affected by your legislation.

I intend to become a crusading member of organizations, now forming, who recommend outright recision of this horrendous law. I think we will give you a good run for your money.

Yours truly,

Fred E. Kauffman.

Attachment.

Congressman **Robert T. Matsui**,
Rayburn House Office Building,
Washington, DC.

Dear Mr. Matsui: I wish to go on record as advocating recision of "The Medicare Catastrophic Protection Act." (HR 2470)

The method established for paying the cost of this monstrous legislation is outrageous. I can understand an increase in premium to every covered individual to take care of additional expense. But for the senior citizens who pay income tax to be penalized by the levy of an income tax surcharge, to cover the economic shortfall of the project, so as to provide coverage for indigent eligible seniors is the most diabolical scheme I could ever imagine. According to now published schedules my income tax will be increased by a staggering $1,700 per year the second year to carry the "have nots." On top of that I have been unable to ascertain any benefit to me from this "Catastrophic Medical Care Act."

The promotion of this Act by AARP is a vicious deceit. Everybody knows that AARP's reason for being is to sell automobile and other forms of insurance. It is news to me that they are supposed to represent the interests of the senior citizen group otherwise. It surprises me that they are so skillful in influencing our legislators into passing such an awful scam. To be sure the arithmetic of who pays what was not publicized before the act was passed.

It would be my first recommendation that the Medicare Act be rescinded in its entirety. Failing that, I would hope that a fair method of paying the cost be levied equally against all of those entitled to its "so-called benefits."

Yours truly,

Fred E. Kauffman.

Senator **Lloyd Bentsen**,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen: I am joining the many others who protest the health surtax which has occurred as the result of the Medicare Catastrophic Act of 1988.

Up until this past year, I have been able to live fairly comfortably on the money derived from a state retirement program and my social security benefits. My health insurance premiums are deducted from both those checks so that I am assured of health care if needed, and at a manageable amount of money.

Having passed by 70th birthday, I was able last year to increase my income by working at a part time job past the limit imposed by IRS, which has provided me the opportunity to own and maintain my home and not be dependent on another person or a public welfare program.

For the first time, I have had to pay nearly $500 in taxes and next year will have an additional $150 (approximately) health insurance premium when I submit my taxes. with each drain on my finances, it becomes harder and harder to remain independent financially.

Why do we keep on imposing programs on the retirees that force them to rely on public agencies? I don't believe that is what America is all about. And, it is certainly a more expensive way for the taxpayer to take care of those who would not otherwise be in need.

Sincerely,

Margaret L. Kemp.

June 13, 1989

Senator Lloyd Bentsen
Chairman, Senate Fiance Committee
Rm 205, SenateDirksen Office Building
Washington, D.C. 20510

Dear Senator Bentsen:

The subject of this letter is PL 100-360 - The Medicare Catastrophic Coverage Act of 1988.

I have, previously, written to President Bush and my Senators from California, Alan Cranston and Pete Wilson on this subject.

I have read that your Committee is conducting hearings on the financing aspects of PL 100-360 and feel that it is important that I , also, transmit my views to you. I am one of the many senior citizens that feel the financing aspects of Pl 100-360 is unfair and discriminatory.

PL 100-360 is a wolf in sheep's clothing. While the additional "catastrophic coverage" will be a boon to those who have never had this kind of coverage before, the coverage comes at a significant cost to older Americans who have financially prepared themselves for retirement. PL 100-360 hurts the middle-income seniors who have planned, saved and invested for their "Golden Years" to avoid sole or primary reliance on Social Security. In addition, the law violates every promise Congress made in passing the 1986 Tax Reform Act, when many deductions were exchanged for lower tax rates and Congressional pledges not to undo the effect of reform by increasing rates. Further, under PL 100-360 the supplemental premiums and tax surcharge will not be treated as a medical expense for tax purposes. In essence PL 100-360 is not only a health care law but also an income tax law. But, not a tax law for everyone, only for approximately 40% of the Senior Citizen social security recipients.

According to many analysis I have read concerning the surcharge aspects of PL 100-360, approximately 60% of all social security recipient tax payers will pay no surcharge, about 35% will pay a graduated surcharge and 5% will pay the full surtax. PL 100-360 places the cost squarely on us Americans who have worked diligently, saved and carefully invested to provide financial security in our later years. People, like myself, a retired Air Force Officer, who served 30+ years active duty, fought in three separate wars, undertook a post military retirement second career and who prudently planned for their wives and their retirement years are now about to see our "OX GORED"!

In the latter instance, this Catcap, taxing retirees, even Medicare itself, would be unnecessary for military retirees if Congress had kept its pledge to afford lifetime health care in military hospitals and treatment facilities.

PL 100-360 doesn't just provide "benefits" for the over 65 social security recipient. It provides benefits for a catch-all list of persons. The disabled poor under 65, Medicaid patients and AIDs patients all are eligible for Catcap benefits. In essence, PL 100-360 is a welfare program paid for by Seniors who pay income taxes.

One of the more popular conceptions concerning PL 100-360 is the Cap at $1370 per year the total amount of out-of-pocket expenses which a beneficiary would have to pay for all medical services under Part B, including physicians services. This conception is both misleading and inaccurate. The $1370 Cap is for 1989. The Cap rises to $1900 in 1993 and there is no assurance that it will not go further in 1994. As each Cap amount rises so does the surtax. No one knows where it might be in 1996. Further, the $1370 cap is not on all out-of-pocket expenses. It applies only to the Medicare approved amounts. With this latter consideration in mind, one would have to incur approximately $6500 each year in medicare-covered expenses. The Law ignores the difference between actual Physician fees and the Medicare approved amounts. My actual experience (two major surgeries, Wife) has been that Medicare approves only 45 to 60% of the physicians charges and in the neighborhood of 55 to 75% of laboratory, X-Ray, diagnostic test costs. I am currently doing battle (a most descriptive word) with the Medicare Carrier in my area over a contested amount of $2500 in approved charges versus actual fees in my wife's last surgery. I requested a Hearing on this case in July 1987. The Case is still pending. This $2500 would not have been considered under the current PL100-360 because the $2500 is the difference between the physicians charges and the Medicare approved amounts. In my research of the Medicare Law, Medicare guidlines and Medicare Carriers Instruction Manuals, I found, much to my dismay, that some of the formulas used by Medicare to compute "Reasonable" costs are over 17 years old.

I have been and continue to be covered by a supplemental Medicare policy issued under the auspices of the Retired Officers Association. The annual premium for both my wife and I, to include outpatient, in hospital and perday hospital benefits, is $1416 per annum. This policy pays the 20% differential costs and covers all costs once my out-of-pocket expenses exceed $1000.00. If the physicians bill is $200, Medicare approves $120 and pays $96 (80%), the supplemental insurance pays $24 (20%) and records $80 as out of pocket expense computation. PL 100-360 does not do this! The cap cuts in only when the approved amount exceeds $1370. My question is: Why should I be forced to pay $400 more per annum in premiums for a medical coverage that is less than what I already have?

The financing aspects of PL 100-360 establishes some unusual tax precedents, to wit, those who are served should pay, exclusively, for the service. With this new tax theory, then, it follows that the Congress should add a surtax to all economically viable tax paying farmers in order to pay for all federal farm subsidies. Or, perhaps, all economically viable taxpaying boat and ship owners should pay a tax surcharge to finance the operations of the Coast Guard. As you know, if we were to continue this line of analysis and applied the same theory of tax surcharge under PL 100-360, then a myriad of the Federal support programs could become self-supporting.

I could go on for several more pages, but in the interst of brevity, I will close with the following points:

(a) About 70 percent of those who are being forced to finance Catcap are covered by health plans or supplements providing them equal or better benefits than PL 100-360

(b) Lower and middle income retirees will incur the greatest percentage increase in their taxes.

(c) Retirees are given no option, they are forced to participate in Catcap, regardless.

(d) Health care programs for 65+ years old Social Security recipients should not include a panoply of beneficiaries.

(e) Taxing Seniors for catastrophic protection is the same as forcing only income tax paying parents with school age children to pay a surtax to cover all federal education benefits or requiring the income tax paying farmer to pay a surtax to finance federal farm subsidies.

In closing, PL 100-360 is much more significant for the heavy taxes it assesses than for the benefits it purports to give. I encourage you and your Committee to review the inequities in this law and develop actions designed to limit applications of the law to only Social Security recipients 65 years and older; to revamp the financing formula/theory; to re-study and review the projected costs; and, most importantly, amend the law to include the option to either take the Catcap coverage or reject the coverage.

Respectfully yours,

Rudolph C Koller Jr

Rudolph C. Koller, Jr.
Col. USAF-Ret. & Professor Emeritus

1404-4A Stanley Dollar, Dr.
Walnut Creek, Ca., 94595

Senator Lloyd, Bentsen,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Re: Medicare Catastrophic Act of 1988

Dear Sir: I wish to protest this grossly unfair Tax.

When my youngest child entered High School I returned to work. I worked for 25 years, the last 20 for County Civil Service. I purchased a used car, which I drove for 20 years. We put 2 children through the University of California in San Francisco. I put the maximum allowed into the county retirement fund. When deferred compensation became available I put the maximum allowed into that account also, in addition I paid into an IRA account.

I have supplemental Medical Insurance and Dental Insurance throw retirement and secondary coverage on my husbands retirement, we pay $34 a month for the extra coverage. I pay $500 per year for Nursing Home Insurance—due to Medical problems my Husband is not eligible for this coverage. If the need arises we will just have to pay the full amount of his care.

Why should those of us who planned and saved for our old age, now be penalized?

Audrey A. Koza.

Senator Lloyd Bentsen,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen: On December 12,1988 we wrote to you regarding our concern of the passage of the Medicare Catastrophic Act of 1988. We than you for your reply on January 11, 1989.

It has come to our attention that you are chairing the hearings, that began on June 1st, to review the Medicare Catastrophic Act. We sincerely hope that changes for the better will come about. As we stated in our letter of December 12, 1988, we can understand the increase in our monthly Medicare premium, plus the $4.00 monthly surcharge for the Catastrophic illness, but fail to understand the surcharge on our income tax. Those of us who worked hard and saved for our old age so that we would not become a burden on others, are being punished. Those who failed to make any effort to prepare for old age will benefit at our expense.

Few will benefit from the income tax surcharge. Elderly patients are usually discharged from the hospital before they are able to care for themselves. Some are fortunate enough to have someone help them, but many are unable to care for themselves or unable to pay for the cost of home care. We feel the need is far greater for custodial care after the patient leaves the hospital.

Thank you for trying to correct an injustice.

Sincerely,

Wayne and Victoria Lakso.

Senator Lloyd Bentsen,
Chairman, Senate Finance Committee,
Senate Office Building,
Washington, DC.

Dear Senator: I would like to express my objection to the Medicare Catastrophic Act of 1988. I do not feel that a particular age and tax group should be singled out to support the cost of this legislation.

As I understand Medicare, the fees we pay are equal for everybody that qualifies. If this kind of coverage is something you feel is needed for the populace, then tax the entire populace an equal amount of money.

I really don't understand why people who have been prudent during their working years, to guarantee themselves an enjoyable retirement, should have to shoulder the lion's share of this program, just because they have higher incomes in retirement than those who have "spent it all" along the way.

Planning for retirement is tough enough these days without having to contend with ideas like this one. I shudder at the thinking that is now beginning to come out of Congress that would set up a means test in order to collect Social Security.

I ask that as your committee is holding hearings on the Medicare Catastrophic Act of 1988 that you consider:

(1) Dropping the whole idea

(2) Set up the funding on a broad base and equal costs to everybody. The benefits that rare collectible are the same for all.

(3) Increase the current Medicare fee by 10-15% and fund whatever else is necessary by an increase in the Social Security tax.

Sincerely,

LUDY E. LANGER.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Bldg.,
Washington, DC.

Senator: The new supplemental income tax is blatantly unfair to citizens such as myself whose incomes are just above what is considered the poverty level and who are ineligible for any breaks on items such as P.G.&E., telephone, etc. I just saw an item in the local paper which stated there is help for renters if their incomes are $13,200.00 or less.

My total income for 1988 was $14,285.60 (including Social Security Income) on which I paid $551 Federal Income tax. Medical insurance for 1988 amounted to $441.00 and will go higher in 1989. Subtracting these two items leaves me with $13,293.60 or just over $1100.00 for rent ($550.00 per month), heating costs, telephone clothing, food, doctor, dentist, eye glasses, etc. And you are going to make me pay approximately $83 additional income tax? That, too, will go higher in future years.

My total Medicare benefits for 1988 were $124.83. True, I have been one of the more fortunate who enjoys fairly good health; however, I know of cases where I am paying for people who can well afford to pay more than an equal share of health insurance costs. Believe me, if I could stay on Medicare without participating in Catastrophic Health Care, I would do so. In my opinion, it is the worst piece of legislation Congress has ever passed.

I am not protecting the raise in Medicare insurance rates. We all must do our part, but you must find a way to put more of the burden on those people with more income and stop gauging the poor. Perhaps you could lift the $800 ceiling or establish a lower percentage rate for low income.

If members of Congress think $89,0O0 a year is too little. I'd like them to try to squeak by on the income of some of their constituents.

Respectfully,

HELEN LIPOLD.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washinton, DC.

In re: Medicare Catastrophic Act of 1988

Dear Mr. Bentsen: I don't require the maximum 20 pages to say I have been dumped on.

After a deduction of $31.90 for part B Medicare from my social security check, I net $243.00 per month. For the past 30 years prior to retirement I contributed to my own retirement fun that now pays me $2,307.46. I also earned medical insurance retirement coverage which met or exceeded the Catastrophic coverage in this legislation

I have a few small investments which are being used to put my youngest child through college. I am pleased to be able to make this investment in the future. I have a mortgage payment on my home, and hope to be able to buy a car on credit when it becomes necessary.

I do not view our very modest life style as that of the rich senior citizen.

The imposition of up to *$150* a month additional tax on my income, is too great a burden. I do not deny others have great needs, but the administration of the national health insurance program is a major cause of this excessive fee. (See Consumer Reports June 1989)

I have tried in every way to hold my after retirement obligations to a declining minimum. This act provides for future increases even as my real income decreases. A 3% wholesale price increase this year will translate to a 10% consumers price increase this fall. The majority of my income is from a pension plan I contributed to during my productive years, which only allows a 2% inflation factor.

I ask you to provide a more nearly level planing field, by allowing a portion of my pension income to be non-taxable income. I and those similarly situated should be allowed to count that portion of our non social security income, up to the amount we would have qualilfied1 as non-taxable income. In other words treat a portion of our pension as if it were non taxable social security income.

Sincerely,

STIRLING R. LONG.

Senator LLOYD BENTSEN,
Chairman

Dear Senator: Stubbornness is not a good attribute in a person, a country, a committee, nor a Senator.

It is time to look at the Catastrophic Care Act from the standpoint of the seniors that you represent.

The average person would not knowingly buy health insurance that costs as much as this act demands and that provides as little as this act provides.

Seniors have been hit in recent years by these changes:

1. Tax on Social Security.
2. A change in the capital gains tax.
3. Higher property taxes.
4. Higher insurance rates.
5. Higher medical costs.

All of these things combine to nibble away at our fixed income. The Catastrophic Care Act designed to help us is actually a burglar in disguise continuing to erode our retirement income.

The A.A.R.P. who presents misleading views of seniors opinions is not our spokesman.

The A.A.R.P. derives 42% of its income from insurance companies. The A.A.R.P. is a self serving tax exempt special interest group. Please look at this act again and make the premiums fair for all concerned or repeal it.

Sincerely,

ED MAGORIAN.

STATEMENT OF THE MARYLAND FEDERATION OF CHAPTERS, NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES, BY AL JAMES GOLATO, LEGISLATIVE DIRECTOR

Mr. Chairman and Committee Members: My name is Al James Golato. I am a vice President and Legislative Director of the Maryland Federation of the National Association of Retired Federal Employees (NARFE) with 36 chapters and 26,000 members in the State of Maryland.

Our National Office will be presenting the official testimony for NARFE at this hearing. My statement represents the views expressed in a resolution passed unanimously at our recent state convention (May 21 to 24, 1989), as well as the views conveyed to me during numerous speaking engagements to which I had been invited before NON-NARFE senior citizens throughout the State of Maryland.

We are pleased that your committee is conducting this hearing in response to the persistent outcry of protests from the elderly about the FINANCING PLAN for the Catastrophic Medicare Coverage Act of 1988. But we are disappointed that the hearing is focusing on the AMOUNT of the SENIORS' SURTAX (you call it a "supplemental premium") rather than the CONCEPT.

In short, we feel the financing plan is MISLEADING, UNFAIR and DISCRIMINATORY.

It is MISLEADING because it is called a premium when it has all the characteristics of a tax. It can't be deducted as a medical deduction on income tax returns as other health insurance premiums are; it is payable to the Internal Revenue Service (IRS) with the income tax return; the IRS may assert penalties and interest for late or non-payment as it does with other taxes; it is based on income rather than risk;

and it is progressive unlike other health insurance premiums. As a matter of fact, almost everyone, now that they have become aware of it, call it a tax.

It is UNFAIR because it is imposed on those who neither need nor want the extra coverage because they already have it. In effect, they are required to pay for duplicative coverage.

The seniors's surtax confiscates fixed income from the thrifty who postponed gratification while working to provide themselves an independent and dignified retirement without having to impose on overburdened families or relying on our deficit-burdened government.

With this unfair financing plan, Congress is actually creating dependency where none exists. Congress should be helping those who can't help themselves, not undermining and punishing those who try.

It is DISCRIMINATORY because it, in effect, establishes higher tax rates based on age. Seniors will be paying higher tax rates than any other class of taxpayers on the same amount of income. Where other taxpayers will be paying tax rates of 15%, 28% and 33%, seniors will be paying rates of about 17%, 32% and 38%.

Supporters of this surtax say the financing is imposed on the beneficiaries. This is the most outrageous element of it. As I said earlier, most of those required to pay the surtax neither need nor want it. Yet the law makes it mandatory for those who are Medicare-eligible.

If only seniors are to pay this surtax because they are the likely beneficiaries of the program, will Congress be requiring only the parents of toddlers to pay taxes for the child care benefits it is considering?

Should only depositors in, and owners of, the Savings and Loans fiasco pay for its bail-out?

Should only the most likely victims of the dreaded disease AIDS—males aged 19 to 49—or those whose behavior contributes to their acquiring the disease—pay the billions for Federal government research and public education, and for the costly medication for those who can't afford it?

Of course not! Need I go on?

Such a financing concept, carried to its consistent extreme, can lead to undesirable social fragmentation and generational and fractional conflicts. And it will inspire a Balkanized income tax system.

So why start such an undesirable trend with the outrageously discriminatory seniors' surtax?

We emphatically urge you to reconsider the flawed CONCEPT—repeat, CONCEPT—you've used to finance the Medicare Catastrophic Coverage Act. It should be considered no different than any other public social program for any other element of the population.

The issue of the misleading, unfair and discriminatory financing scheme for the Medicare Catastrophic Coverage Act, and the seniors' protest, will not go away. If anything, it will increase when the 1989 income tax returns are due by April 15, 1990.

We are convinced the best way to correct the problem is to begin by passing Senate bill S. 335—which postpones implementing the FINANCING plan—so that Congress will have time to hold hearings and consider a candid, fair and non-discriminatory way to pay for the Acts' coverage.

I thank you for the opportunity to present this short statement. I am prepared to discuss this matter in greater detail at any future hearings or with a member of your committee staff.

Hon. Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Sir: We or vehemently opposed to the method of financing the Medicare Catastrophic coverage. Taxing senior citizens who worked and planned for their retirement to pay for those who did not is unfair. this type of selective taxation is not right. If this philosophy is to be used then senior citizens should not pay any SCHOOL TAX, BUILDING TAX, ROAD IMPROVEMENT TAXES, etc., as they do not need these facilities.

We feel this tax should be borne equally by all citizens or abolished.

Sincerely,

MARVIN AND IMOGENE MCCLAIN.

MEDICAL GROUP MANAGEMENT ASSOCIATION

The Medical Group Management Association (MGMA), representing the administration of medical group practices across the country, appreciates this opportunity to comment on options for reform of the Medicare Part B physician payment system. We have worked with the Physician Payment Review Commission (PPRC) over the past two years, providing data for research, as well as input and feedback on policy proposals. Similarly, we look forward to working with the Congress as it considers the recent recommendations of the PPRC, as well as short-term Medicare budget cuts required by the budget resolution.

MGMA has nearly 4000 medical groups In its membership, representing almost 85,000 physicians, practicing in every specialty, and in all areas of the country. A demographic description of the membership is attached for your information.

FISCAL YEAR 1990 BUDGET ISSUES

We are keenly aware of the difficult task Congress faces each year when debating the Federal budget. Balancing priorities, assuring that Federal programs are properly funded, and maintaining fairness in public policy are increasingly difficult after several years of increasingly severe reconciliation bills. MGMA is concerned that some of the proposals under consideration for Medicare In FY 1990 are Inconsistent with long-term policy, and can be improved upon if further short-term cuts must be made.

Overpriced Procedures—MGMA opposes the proposed additional 12 percent reduction in payment for procedures the PPRC identified two years ago as "overpriced." The concept of reducing payment for designated procedures is sensible when targeted on physicians who are actually overpaid for the procedure. The proposal as written, however, would potentially penalize everyone performing the procedure.

Although the method used two years ago to calculate the reductions was complicated, it at least distinguished between those who received fees above the national average, and those whose fees were below the national average, and reduced allowable charges accordingly. If budget cuts must be made using this technique, it would be more equitable to use a similar method in determining how much such fees should be reduced.

Reductions in payments for radiology, anesthesiology, and surgery—For many of the same reasons, MGMA opposes the plan for an across-the-board reduction in payments for radiology, anesthesiology, and surgery. This eight-percent feed reduction unfairly penalizes those physicians who perform such services in low fee localities. The policy assumes that all such procedures are overpriced, which is simply not the case.

Across the board cuts are an arbitrary approach to reducing the Medicare budget. They are not based on sound Medicare policy, but rather on a piecemeal approach to balancing the Federal budget.

Fee Freeze—The proposed freeze on physician fee updates is inequitable and unreasonable. If a freeze were to be imposed, the Federal Government would again demonstrate to the physician community that it is an unreliable business partner. Physicians' fee updates should at least keep pace with inflation in the medical economy. Over the past several years, fee updates have not even been equal to the Medicare Economic Index (MEI), which itself is designed to keep physicians' fees down.

Since 1984, physicians' Medicare fees have not been allowed to increase normally. Instead, they have been artificially deflated, and as a result, are much lower in many cases, than fees for non-Medicare patients. A Medicare fee freeze will only exacerbate the problem. Just as hospitals have "cost shifted" to commercially insured and self-pay patients due to Part A payment reductions, so too are employers being asked to unfairly subsidize Part B of Medicare.

Payment ceilings for designated specialty services—The Administration's proposal to establish a ceiling on prevailing charges for services frequently performed by specialists is good in principle, although the proposal itself is very vague, and details obviously have not yet been considered.

If the idea is to assure that the highest fee is paid to the recognized expert for that particular service, the proposal makes good sense. As most Medicare fees are based on historical charges, under current law there is no assurance that a specialist would be paid more for a service than a generalist. We agree that the recognized expert's fee should be the ceiling.

PPRC RECOMMENDATIONS AND THE MEDICARE FEE SCHEDULE

MGMA supports the core concept of the study conducted by William C. Hsiao, PhD, on the development of a resource-based relative value scale (RBRVS); we believe it is appropriate to pay for a physician's service based on the resource input of that service. We commend the Commission for the work it performed following the release of the Hsiao study. The Commission's analysis was extensive, and its research methods sound.

We have three main concerns regarding the PPRC's recommendations to Congress, which involve: a transition from the current payment system to a fee schedule; changes in rules on balance billing; and the use of national expenditure targets.

Transition period—If Congress were to enact legislation calling for a national Medicare fee schedule, it would be vital to provide an adequate transition period to change from the current payment system. A reasonable transition period would be not less than three years from the date new regulations take effect. Just as a lengthy transition was necessary when hospitals changed from a reasonable cost payment system to a prospective payment system, medical groups will also need an appropriate adjustment period. If providers are to see a dramatic shift in income from the implementation of a fee schedule, this time will allow them to better prepare for the change.

Any change in the Medicare payment system usually requires a substantial amount of time for providers to adjust their billing or accounting systems. Providers are often the only source of information to the beneficiary about the Medicare program, so adequate time is also necessary to explain changes to their elderly patients.

Perhaps most importantly the Part B carrier network which administers Medicare is overloaded to the point of "melt down." Carriers have not been able to keep pace with the volume of changes legislated since 1982, and unrealistic statutory deadlines have contributed to repeated instances of confusion and mistakes.

Balance billing—If a Medicare fee schedule is used in the future to pay for physician services. It should not be mandatory for physicians to accept the fee schedule amount as the charge limit. MGMA believes participation in the Medicare program should continue to be voluntary, and that balance billing should be allowed. Arbitrary price controls that result from mandatory assignment are unfair and unnecessary.

The average income for elderly Americans is much higher today than it was over 25 years ago when the Medicare program began. As demonstrated by a recent PPRC study on the effects of balance billings on the elderly, only about one percent of Medicare beneficiaries incur out-of-pocket medical costs of $1,000 or more due to balance billing.

The Congress must make every effort to keep Medicare rates competitive with other payers. Some medical groups have already begun to look to alternative means to maintain a reasonable profit margin. Techniques to manage payer mix, such as limiting the amount of time physicians spend with Medicare patents or limiting the number of Medicare patients a physician could see in a day, are a few of the steps being taken to minimize financial loss when Medicare pays non-competitive rates. *Mandatory assignment in conjunction with a fee schedule would unfairly restrict the options of both beneficiaries and providers, and further impose on employer based coverage to subsidize care for the elderly.*

Expenditure targets—MGMA strongly opposes the institution of expenditure targets to control the growth in Medicare Part B costs. As advanced, this concept is a poor alternative to controlling the growth In spending for physician services. If it leads to true rationing it is the end of Medicare Part B's entitlement status. Beneficiaries are no longer truly insured, they are at the whim of annual appropriation. If instead it is just another guise for continued price controls, it is of the most arbitrary kind.

To expect individual physicians to embrace this concept as an opportunity to achieve the goal of volume reduction is naive. Those physicians who provide an excessive volume of services would continue to do so, while other physicians would suffer the consequences through diminished fee updates.

We are aware of the concern in Congress and in the Administration over the Federal deficit, and we understand the need to control program costs. *However, capping expenditures at some figure derived by some formula still to be determined will do little more than limit the availability of services to Medicare patients, and penalize medical groups that responsibly control utilization through good management, internal peer review, and effective patient/physician education.*

If Government is serious about controlling volume, it should join with the professions and the employer community to establish, through hard research and consensus building, practice standards that distinguish between what the Government is willing to pay for, and what should remain the patient's choice and financial responsibility.

In conclusion, MGMA hopes these issues are given serious consideration during the fiscal year 1990 budget debate and we would be happy to provide further information on these topics. We look forward to working with the Committee members in developing a fair and equitable budget plan for the Medicare program.

NATIONAL ALLIANCE OF SENIOR CITIZENS

THE NATIONAL ALLIANCE OF SENIOR CITIZENS FAVORS COMPLETE REPEAL OF THE MEDICARE CATASTROPHIC PROTECTION ACT

The National Alliance of Senior Citizens (NASC) has opposed the flagrantly misnamed "Medicare Catastrophic Protection Act of 1988" from the time the concept was first introduced by then Health and Human Services Secretary Dr. Otis Bowen in early 1986. In public hearings held around the country, officials of the NASC presented the views of the NASC membership. NASC Medical Director Dr. Bedford Berry testified before several of these hearings, offering his insights from long experience in both the practice of medicine and in the administration of government medical programs.

After traveling all over the country to observe the hearings conducted by the HHS, the NASC saw virtually no support for the legislation outside of political Washington. While there has been widespread disenchantment among senior citizens with the Medicare system, there was neither public demand nor apparent desire to have the extended hospital stay service offered under Medicare.

The astonishing lack of interest in the views of those who would be most affected by the proposal reflected the clear desire to achieve a political advantage among senior voters by their elected officials. The politicians believed that *they* knew what was best for the elderly, and made no efforts to ascertain their true concerns or the willingness of seniors to pay the exorbitant costs of the law.

Rarely, however, do senior citizens rally to fight against what are perceived as "freebies" when offered. And when the slick, but flagrantly false, choice of the term "catastrophic coverage" was used to describe this unnecessary addition, the door was opened to all forms of deception.

The NASC engaged the services of the respected pollster Dr. Richard Wirthlin to gauge the views of those aged 65 and older on issues of catastrophic illness. What we found was that the law totally missed the mark, and the cost of the program was far in excess of the ability or desire of seniors to afford it.

What the Wirthlin survey revealed was that only 23% of older adults agreed with Dr. Bowen and the Capitol Hill politicians that extended hospital stays were their real catastrophic health care concerns. Further, a scant 8% agreed with the *American Association of Retired Persons (AARP)* that it was prescription drugs

Instead, 40% indicated that long term care in a nursing home was their number one "catastrophic" worry. Home health care was the primary concern of 24% of seniors. The poll also showed that few seniors were willing to pay the enormous sums required under the new law, with fewer than 5% willing to pay more than $500 annually for such new Medicare coverage. Some 42% were unwilling to pay anything at all for these benefits!

Interestingly, 61% of those surveyed were members of the AARP—and their views were almost identical to the rest of those polled. This illustrates the degree of misinformation that the Congress and the American people have repeatedly been given by groups such as the AARP, whose enthusiastic support for the prescription drug coverage can be explained by the fact that it operate the largest mail order pharmacy in America and stood to make a fortune from such coverage. As well, the AFL–CIO's National Council of Senior Citizens would lead you to believe that the provisions of this new law were very much desired by the elderly.

Hopefully, Congress will look carefully at the lack of apparent concern those groups have given to the income tax surcharge and the monthly Part B premium hikes. They are now urging you to spread out the costs over all working persons. The fact is the benefits are not worth the costs, and should not be paid for by the American taxpayer, whether elderly or not.

For many seniors, the "catastrophic health" law represents a serious setback financially as it adds a significant increase to the taxes paid by middle income persons ages 65 and older. Those who have saved during their working years so that they would never become a burden on their children or on the taxpayers are being hit hard with this tax to pay for health care for those who did not bother to save.

Regardless of what some politicians and some organizations try to sell as "insurance," this is not insurance. It is a tax on one socioeconomic group of seniors to finance another, with no guarantee of care even for those who pay the most for it. And it is not the first time those who have saved and have planned to provide an adequate retirement income for themselves have been hit hard by the Congress.

The massage that Americans get from this legislation is quite clear: Don't save for your retirement because the politicians we send to Washington will take your savings from you when you pass the age of 65!

The Medicare Catastrophic Protection Act should not be merely relaxed, it should be repealed outright. Any effort to the contrary would do little to make the necessary alterations which would make Medicare more responsive to the elderly who depend on it.

The NASC believes that any move other than complete repeal is yet another cynical political charade against senior Americans. This includes the one year delays many Republican and Democratic Congressman and Senators have signed on to as cosponsors

The NASC instead believes that another program should be adopted which would truly make a difference for the elderly. Our plan would take the present total expenditures for Medicare and maintain them at present levels. It would also shift the involvement of Medicare from today's arbitrary and capricious bureaucratic decision-making on value to a reflection of total cost to the patient during the year. This would offer senior patients genuine catastrophic health coverage under Medicare.

Such coverage would be achieved by setting a maximum amount for the health expenditures an individual would be responsible for paying during the calender year. After demonstrating to Medicare that the sum had been reached, the government would cover all other health care for that year.

Most seniors—as we have seen—would purchase supplemental insurance to cover their financial responsibilities. For those with insufficient resources to afford private insurance, vouchers would be provided from Medicare funds.

The NASC does not have actuaries on its staff to scientifically project the cost of this proposal, but it is our estimate that if seniors were responsible for the first $5,000 annually, and 50% of the next 5,000—or a total of 7,500 a year—Medicare would pick up the rest, regardless of where the money was expended.

Thus long term nursing home and home health care as well as hospital and doctor care would be covered—and at no additional cost to the taxpayer or the elderly. It would give senior adults a finite program which offers actual coverage that can easily be understood, not one that leaves them confused and left holding the bag for the large sums that Medicare now refuses to pay.

It is our hope that such a plan will receive the most serious consideration by members of this committee and by the Congress as a whole.

Few matters offer greater concern to senior adults than the specter of a health crisis which requires an extended stay in a hospital or nursing home. Seeking to capitalize On this most serious worry, politicians of both parties have come up with a law which they tout as the answer to the health dangers of the elderly.

The catastrophic health care law, however, fails to address the real problems involved in health care for our nations senior citizens. Indeed, the law has created new problems. The NASC urges its repeal, and seeks responsible answers to the genuine concerns of elderly Americans.

STATEMENT OF THE NATIONAL ASSOCIATION FOR UNIFORMED SERVICES AND THE SOCIETY OF MILITARY WIDOWS

Mr. Chairman and members of the committee, I appreciate the opportunity to present the views of the National Association for Uniformed Services and the Society of Military Widows to this distinguished panel.

The National Association for Uniformed Services and the Society of Military Widows are unique in that we represent all grades and ranks of uniformed services personnel and their spouses and widow(er)s. Our membership includes active, retired, reserve and National Guard personnel, disabled and other veterans of all seven uniformed services: Army, Navy, Air Force, Marines, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration. Our Society of Military Widows is an active group of women who were married to uniformed services personnel of all grades and ranks and represents a broad spectrum of military society.

In addition to our paid enrolled membership of over 55,000, we are In frequent contact with an additional 40,000 widows and 1.1 million, mostly retired, uniformed personnel and their families who are supportive of NAUS/SMW. With this membership and support, we are able to draw information from a broad base for our legislative activities. Our members are expressing increased concern and outrage over the high cost of the Supplemental Premium provision of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360).

While recognizing that the law was passed with the best of intentions, the discriminatory and inequitable supplemental premium surtax has created a major economic problem for people of modest means.

The new law requires older Americans to pay for the increased Medicare benefits because, purportedly, "they are the ones who use them." However, that is not the whole picture. Disabled individuals of any age may qualify for Medicare. That means young people who have been crippled by accidents and people with degenerative diseases will receive the benefit. Individuals in such circumstances pay a premium also, but only after becoming disabled. Over 3,000,000 Americans under the age of 65, paid no prospective Medicare Catastrophic premium, yet currently receive the benefit. Every employee of every age in Social Security covered employment may benefit from this law, yet they pay no prospective premium. Over forty percent of the elderly will pay the premium surtax of the remaining elderly and disabled.

Seventy percent of Medicare enrollees who will be required to pay the supplemental premium surtax already pay for "medigap" insurance policies which provide benefits equal to or greater than those provided by the new law.

Because of the high deductibles and other gaps in P.L. 100-360, our senior citizens must still continue to enroll in a Medicare supplemental insurance program, therefore there are little or no offsetting savings as a result of the program.

The supplemental premium is a 15% surtax on the income tax owed. This surtax is in addition to the tax on Social Security enacted a few years ago. One analysis shows that the marginal tax rate for a couple drawing Social Security whose income at the $34,000 level could be 42%. Add to this the Medicare Catastrophic supplemental premium surtax of 15% on income tax due and you have in the words of one of our members, an "atrocity of legislation."

The supplemental premium surtax particularly hurts military retirees, their families and disabled veterans who were promised health care in military and Veterans Administration hospitals. Special provisions placed in the law to provide equity for Federal civilian retirees do not apply to military retirees and veterans, who must pay for a benefit already provided for by law.

We have developed charts (Tab A) showing the compounding effect that the Medicare Catastrophic Coverage Act supplemental premium has on Social Security recipients. In our example we show typical officer and non-commissioned officer retirees.

As the charts indicate, the over 65 officer pays a greater tax by $2,640 than his under 65 counterpart, while the older NCO pays an additional $1,096.

A major problem of the Medicare surtax is that it was not factored into the retirement planning of our members, therefore it is an unexpected expense to be paid from fixed income. The result can be devastating. We agree with the concept that those who use the benefit should pay for it; but this is not the case for the over forty percent who pay the surtax for everyone else including those under 65 years of age. The concept of fairness should be expanded to me the program voluntary. This would allow those who already have plans to continue them without having to shoulder an additional tax burden for benefits they do not need nor want.

We urge your support of two bills. These bills, S. 335 by Senator John McCain and H.R. 1564 by Representative Peter Defazio, would preserve the major benefits under the new Medicare Catastrophic Coverage Act: long term hospital care and protection against spousal impoverishment. The bills would delay for one year the requirement for the 15% surtax or supplemental premium. This will give Congress time to review and adjust that part of the law and eliminate the cause of the Seniors' most serious and widespread dissatisfaction.

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Established 1968

SOCIETY OF MILITARY WIDOWS

MEDCAT SURTAX IMPACT

Both Husband and wife over 65 - 1989

		Officer Pay Grade 05		Enlisted Pay Grade E8
Gross Retired Pay:		$ 32,364		$ $19,032
Interest, Dividends,Etc		5,000		2,000
Part-time Employment		12,000		10,000
Social Security				
Total	$ 10,000		$ 8,000	
Taxable		$5,000		$1,516
Adjusted Gross Income		$ 54,364		$ 32,548
Personal Exemption		(-) 4,000		(-) 4,000
Schedule A-1040		(-) 8,000		(-) 6,500
TAXABLE INCOME		**$ 42,364**		**$ 22,048**
TAX		$ 7,998		$ 3,304
MEDCAT SURTAX 15%		1,200		496
TOTAL TAX		**$ 9,198**		**$ 3,800**
Now add in the Social Security Earning Penalty on part-time income (12,000 - 8,800) / 2 =		$ 1,600	(10,000-8,800) / 2 =	$ 600
GRAND TOTAL		**$ 10,798**		**$ 4,400**

-over-

MEDCAT SURTAX IMPACT (continued)

Compare the figures with same Taxable Income for one under 65 years of age.

TAXABLE INCOME	$	42,364	$	22,048
TAX		7,998		3,304
MEDCAT SURTAX		- 0 -		- 0 -
TOTAL TAX:	$	7,998		3,304
		vs		vs
	$	10,798		4,400
THE DIFFERENCE THE OVER 65 PAY IS:	$	2,800	$	**1,096**

- 1993 -

In 1993 the surtax rate goes to 28%. Use the same income tax liability of $7,998 for the Officer Pay Grade O5 and $3,304 for Enlisted Pay Grade E8 and see what happens.

TAX	$	7,998	$	3,304
MEDCAT SURTAX 28%		2,239		925
TOTAL TAX	$	10,237	$	**4,229**

NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

While National Committee members believe that there are many fine features of the Medicare Catastrophic Coverage Act, they have expressed their concern throughout the legislative process about the 100 percent senior financing and the lack of long-term care coverage. Our members have sent over 1.5 million post cards urging Congress to revisit the Medicare Catastrophic Coverage Act. Consequently, Mr. Chairman, they are pleased that you are conducting this hearing.

Mr. Chairman, the social insurance concept has served the people in this country well. Millions of Americans support Social Security and Medicare because of the economic security it has provided citizens of all ages. The departure from social insurance financing—along with the "seniors only surtax"—came as a shock to seniors. Social insurance financing is also the only reasonable way to pay for catastrophic long-term care coverage—the real catastrophic problem which is not addressed in this legislation.

The National Committee endorses legislation which Senator Harkin plans to introduce. This legislation would eliminate the surtax and spread the financing by increasing taxes on all higher income individuals. The long-term care problem could begin to be addressed by passing home health care legislation similar to that introduced by Senator Simon and Congressman Pepper in the last Congress. There would be no better tribute to "Senator" Pepper than passing his home health care legislation.

One of the issues being examined today is the extent of excess revenues and the use of them to balance the budget. We couldn't agree with you more strongly that older Americans should not pay more for a bookkeeping gimmick that allows the government to avoid tough choices on the budget.

National Committee research early this year indicated that the Joint Committee on Taxation underestimated taxpaying beneficiaries by 24 percent (Report attached). The Joint Committee on Taxation has since revised its estimates upward, but only by 16 percent. These estimates may still be low because the Administration has estimated nine percent higher revenues than the Joint Committee on Taxation.

Almost half of all seniors and one-fifth of the disabled will be liable to pay the surtax for 1989, according to National Committee research. We believe this estimate is conservative; it assumes no increase in the percentage of senior taxpayers between 1985 and 1989—contrary to the trend between 1980 and 1985. The political significance of these numbers is just as important as the impact on revenues. if almost half of seniors are paying the discriminatory surtax, it is more than just the rich who are paying. So a 16 percent surtax reduction will not reduce opposition.

The National Committee hopes that the Committee would address all the following problems surrounding the Catastrophic law:

- seniors now pay the highest marginal tax rates in the country which penalizes their thrift and industriousness
- catastrophic legislation was supposed to provide protection from catastrophic health care expenses, but individuals with annual income above $13,000 will pay *more* for health care, according to the Congressional Budget Office (see Research Report)
- the Administration's 1987 Task Force on Long-Term Care reported that 81 percent of seniors' out-of-pocket health care expenses over $2,000 go towards long-term care, yet the Medicare Catastrophic Coverage Act provides almost no coverage for long-term home health or nursing home care
- seventy-two percent of Medicare enrollees already had generally equivalent catastrophic coverage through medigap insurance or Medicaid
- farmers alone aren't asked to pay for farm benefits, veterans alone aren't asked to pay for veterans benefits and parents alone aren't asked to pay for schools

Some of the big winners with this legislation are big business and governments at all levels, because this legislation will reduce by $40 billion the liability for health benefits which they promised to pay their current retired employees (see appendix). The National Committee sees no reason why those seniors who have managed to save for their retirement should now be obligated to subsidize the previous health care commitments of major employers.

The National Committee wants to commend the Committee for improving coverage for low-income retirees. They desperately need this coverage, previously beyond their financial reach. But this doesn't justify seniors alone paying higher taxes. Seniors, however, continue to be willing to pay their fair share of taxes for programs that benefit society.

The National Committee's members believe that Medicare is not a "senior only program" inasmuch as it relieves the entire family of the burden of escalating medical bills incurred by the vulnerable aging population. As such, the program is benefiting all of society. Therefore, the costs of the program should be borne by the entire society. Medicare also promises protection for today's current workers.

It is illustrative to note that Medicare passed in the mid-sixties because of political pressure from middle-income, middle-aged individuals because they could not keep up with their parents' medical bills and buy a home and save for the education of the "baby boom" generation.

We urge this Committee and the Congress as a whole to address seniors' primary concerns about the Medicare Catastrophic Coverage Act the failure to finance new benefits through social insurance and the omission of meaningful long-term care coverage.

As a fellow Texan, Mr. Chairman, I want to commend you for holding this hearing and examining all facets of the Medicare Catastrophic coverage Act and its impact on seniors. Your initiative is illustrative of your reputation as a caring and responsive Senator.

APPENDIX—PRESENT VALUE OF EMPLOYER LIABILITIES FOR RETIREE HEALTH INSURANCE BENEFITS FOR CURRENT RETIREES, 1988

[billions of dollars]

	Before Catastrophic	After Catastrophic	Difference
Public Employees	$33	$23	$10
Private Employees	98	68	30
Total	131	91	40

Source: Deborah 7. Chollet, "Retiree Health Insurance Benefits: Trends and Issues," in ***Retiree Health Benefits: What is the Promise?*** Employee Benefit Research Institute, Washington, DC., p. 30. Calculation of the liability before catastrophic was based on the author's assumption that, "On average, corporate and public employer liabilities are estimated to decline by approximately 30 percent as a result of new Medicare benefits." The author assumed universal Medicare coverage for public employees. In reality it is approximately 95 percent.

MEDICARE CATASTROPHIC COVERAGE ACT: MORE OUT-OF-POCKET COSTS, LITTLE OR NO BENEFIT

Research Report by the National Committee to Preserve Social Security and Medicare

NUMBER OF SENIOR TAXPAYERS UNDERESTIMATED

National Committee estimates, based on income tax returns filed by seniors, show that 14.6 million seniors, almost 47 percent of older Americans, will have a tax liability of more than $150 in 1989 and will, therefore, be required to pay the Medicare tax.[1] A state by state breakdown of the 14.6 million seniors with this tax liability appears in Appendix B of this study. The percent of senior taxpayers ranges from 35 percent in Mississippi to 57 percent in New Jersey and Connecticut. By 1993, almost 54 percent of this nation's seniors will pay the Medicare tax.

Medicare enrollees include not only seniors, but about 3.1 million disabled. If the disabled Medicare population is included, 44.1 percent will pay the surtax.[2] This figure is considerably higher than what the government has estimated. According to CBO, only 35.6 percent of Medicare enrollees will pay the supplemental tax in 1989. The percentage will gradually increase over the next five years, but not until 1993 does CBO predict this percentage will reach 42.5 percent.[3]

The National Committee arrived at its estimates by analyzing actual tax return information, published by the Statistics of Income Division of the Internal Revenue Service (IRS) on taxable returns by seniors 65 years and older. According to IRS data, the percentage of seniors paying taxes above an average of $150 has steadily increased from 1980 to 1985. In 1980, only 34 percent would have been liable for the surtax, had the law been in effect. By 1985, however, about 47 percent, or 13.4 million seniors paid an average of more than $150 in Federal taxes. Applying just the same 47 percent to the number of people aged 65 and older in 1989 shows that 14.6 million seniors will have tax liabilities of more than $150.

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[1] See Appendix A for a methodology presentation.

[2] See Appendix C and D.

[3] The Medicare Catastrophic Coverage Act of 1988. Staff Working Paper, Congressional Budget Office, August 1, 1988.

The Medicare Catastrophic Coverage Act of 1988, signed into law on July 1, 1988, requires beneficiaries, in addition to an increased monthly premium, to pay a supplemental premium based on their federal income tax. For every $150 tax liability, seniors will have to pay an additional $22.50 in taxes for Medicare, up to a maximum of $800 for individuals filing singly and $1,600 for those filing as couples. This additional premium amounts to a 15 percent surtax in 1989—the first year the tax is due. The surtax increases each year thereafter, reaching 28 percent by 1993, or $42 for every $150 paid in Federal taxes.[4]

For example, an individual, or couple, with a tax liability of $3,000 will pay a supplemental premium of $450 in 1989. A single person with a tax liability of $5,300 or more will pay the maximum supplemental premium of $800. A couple with a tax liability of $10,667 or more will pay the maximum premium of $1,600.[5]

MOST SENIOR TAXPAYERS WILL BE WORSE OFF

According to CBO, the net result of the Medicare Catastrophic Coverage Act will "reduce out-of-pocket costs for the poor and near-poor enrollees, while increasing costs for other groups.[6] CBO reached this conclusion despite their statement that "Congress attempted to ensure that the full value of new Medicare benefits would accrue in some form to enrollees with medigap insurance as well, although attainment of this goal is uncertain.[7] Based on CBO's own estimates, 30 to 40 percent of Medicare enrollees—most of the seniors paying the surtax—will suffer greater out-of-pocket cost for Medicare covered services after the law goes into effect. This is true even after adjusting for reductions in medigap premiums.[8] In its report, CBO simulates a fully effective law in 1988 including all the benefits which according to the law will not be effective until 1993.

Perhaps most surprisingly, individuals with annual per-capita incomes above approximately $13,000 will lose from this legislation. Between nine and ten million beneficiaries will spend about $100 more a year for their health care coverage—even after the reduction in medigap insurance is taken into consideration. Furthermore, if CBO has underestimated the number of enrollees paying the supplemental premium surtax, it would also have underestimated the number of enrollees who will be worse off.

Beneficiaries who have employer-provided medigap benefits and who also pay the supplemental premium will have an average premium increase of $333 in 1989 for no increased benefit. Twenty percent of Medicare enrollees receive medigap benefits paid by employers. Some employers are required to make premium rebates, but these will be very small in 1989.[9]

BENEFICIARIES WILL RECEIVE FEW NEW BENEFITS

Many have criticized the new law because it primarily duplicates benefits that most Medicare beneficiaries already received through medigap insurance or Medicaid. Far from being an historic expansion of Medicare, the new benefits for all beneficiaries are very limited, consisting primarily of new drug coverage.

Sixty-two percent of all Medicare enrollees and 72 percent of seniors already had medigap coverage. This means that for a majority of enrollees most of the benefits included in the catastrophic benefit package were covered by private insurance. Another 10 percent of Medicare enrollees receive Medicaid assistance and were already protected against these out-of-pocket costs. The remaining 28 percent of beneficiaries who cannot afford, cannot qualify, or have chosen not to purchase medigap policies, stand to gain the most from the catastrophic coverage law.

An analysis of the benefits under the Catastrophic Coverage Act reveals that only 24 percent of the benefits were not usually covered through private medigap policies.[10] The only new benefits Medicare enrollees with medigap coverage will receive are prescription drug coverage, no 3-day prior hospital stay before entering a nursing home, unlimited hospice days, additional home health care, 80 hours of respite care, and mammography tests.

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[4] PL 100-360, Medicare Catastrophic Coverage Act of 1988.

[5] See Appendix F for the 1989 tax table for the supplemental premium.

[6] CBO Staff Working Paper, p. 20.

[7] Ibid, p. 17.

[8] Ibid. Based on Table 11, p. 22.

[9] The Health Care Financing Administration announced the national average actuarial value of duplicative Part A benefits to be worth $65 in 1989. Federal Register, Dec. 6, 1988.

[10] See Appendix E.

CONCLUSION

The National Committee has found that about 47 percent of seniors will have a tax liability of $150 or more in 1989, thereby paying additional Federal income tax as a result of the new law. In addition, it was found that most senior taxpayers will be worse off and face even higher out-of-pocket expenses for their health care. These factors further explain the broad dissatisfaction currently being expressed by many seniors—a dissatisfaction which is likely to continue to grow as the number of senior taxpayers grows.

ADDENDUM

CBO has stated that supplemental premium information was prepared by the Joint Committee on Taxation also using income tax returns. The Fiscal Year 1990 Administration budget [11] estimates that revenues from the surtax in 1989 are 55 percent higher than estimated just last summer. This supports our conclusion that the percent of Medicare enrollees paying the surtax has been underestimated by Congress.

APPENDIX A—METHODOLOGY FOR CALCULATING SENIOR TAXPAYERS

NUMBER OF SENIORS WITH AN AVERAGE TAX LIABILITY GREATER THAN $150 IN 1985

To calculate the number of seniors with a tax liability of $150 or more in 1985, we used *Individual Income Tax Returns* yearbooks from 1980 through 1985 published by the Statistics of Income Division (SOI) of the Internal Revenue Service. First, the number of taxable returns filed by aged 65 or over were obtained from Table 2.5 p. 76 of the 1985 yearbook—entitled, "Returns of Taxpayers Age 65 or Over: Selected Income and Tax Items, by Size of Adjusted Gross Income." The nontaxable returns were deducted as were the returns with an average tax liability of less than $150. Table 2.5 p. 76, "Total Tax Liability" column provided the number of tax returns by income group and the total taxes paid by that income group. An average tax liability was calculated per income group. When a group of returns had an average tax liability of less then $150, the entire group was disregarded.

The number of individual taxpayers age 65 or over was calculated from Table 2.6 p. 77 of the 1985 yearbook as shown above. The total number of individuals with tax returns with an average tax liability greater than $150 was derived by multiplying this number with item C (see p. 9). A similar calculation was done for years 1980–1984.

Population data of seniors was obtained from two sources: *Statistical Abstract of the United States 1988,* Resident Population Table 20, "Resident Population by Age, Sex, and Race: 1970 to 1986;" and, Table 6 "Projections of the Population, by Age, Sex and Race for the United States: 1983 to 2080," Bureau of the Census, *Projections of the Population Series P-25. No. 952.*

This report found that between 1980 and 1985 the percentage of senior taxpayers has grown from 34 percent to 47 percent. It would be reasonable to assume that the percentage of senior taxpayers has continued to increase since 1985, because each new age 65 cohort is generally wealthier than the previous age 65 cohort. However, our report conservatively assumes no increase in the percentage of seniors paying tax since 1985. Aldona and Gary Robbins, tax consultants, found that under the original House bill, H.R. 2470, approximately 46 percent of seniors would pay some supplemental Medicare premium had the bill been in effect in 1988. (Institute for Research on Economics of Taxation, *Economic Report,* May 23, 1988, p. 11.)

We considered whether the 1986 tax reform law had increased or decreased the number of senior taxpayers. We consulted several tax economists who concluded that there was no significant difference in the numbers of senior taxpayers before and after the law went into effect.

This report talks about the tax liability of all seniors 65 and over, not senior enrollees in Medicare. While all seniors are not *enrolled* in Medicare, most seniors are *eligible* for Medicare Part A on the basis of their Social Security or railroad retirement entitlement, and therefore liable for the supplemental tax. Seniors who are eligible for Medicare but do not enroll are primarily employed and have employer-provided health insurance which is the primary payor.

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[11] Budget of the United States Government, Fiscal Year 1990, p. 4-11.

PERCENT OF SENIORS WITH A AVERAGE TAX LIABILITY GREATER THAN $150 IN 1985

	No. of returns	No. of individuals
Number of joint returns with both filers age 65 or over (Table 2.6, p. 77)	3,541,629	7,083,258
Number of returns by primary taxpayer age 65 or over (ibid.)	1,814,430	1,814,430
Number of returns by secondary taxpayer age 65 or over (ibid.)	379,099	379,099
Number of separate returns of husbands and wives age 65 or over (ibid.)	63,988	63,988
Number of returns by head of household age 65 or over (ibid.)	180,926	180,926
Number of returns by surviving spouses age 65 or over (ibid.)	9,171	9,171
Number of returns by single persons age 65 or over (ibid.)	4,321,129	4,321,129
Total	10,310,372	13,852,001
A. Total number of returns with a tax liability (Table 2.5; p. 76)	10,310,372	
Less non-taxable returns (ibid.)	231,768	
Less returns with average tax liability of less than $150 (ibid)	133.620	
B. Total number of taxable returns with tax liability of $150 or more	9,944,984	
C. Percent of returns with tax liability who would be liable for the supplemental tax (A/B) = .96456112		
D. Total number of individuals with taxable returns age 65 or over		13,852,001
E. Total number of individuals with taxable returns with an average tax liability greater than $150 (DxC) =		13,361,103
F. Total number of seniors age 65 or older in 1985 (Statistical Abstract of the United States, 1988, Table 20, p. 17)		28,536,000
Percent of total senior population with average tax liability greater than $150 (E/F) = .4682 = 47%		

NUMBER OF SENIORS PAYING MEDICARE SUPPLEMENTAL TAX IN 1989

Estimated population 65 or older in 1989 (U.S. Census Bureau) 31,115,000
Number of total senior population with average tax liability greater than $150 = (31,115,000x46.82%) = 14,568,000.

The National Committee has estimated that in 1985 46.8% of seniors would be paying supplemental tax had the program been in effect. We are making the conservative assumption that this percentage remained the same trough 1989. For future years, we applied the 6.9% increase over five years used by CBO.

	1989	1990	1991	1992	1993
Percent of senior beneficiaries paying supplemental premium	46.8	48.3	50.2	52.0	53.7

APPENDIX B—STATE BY STATE BREAKDOWN

To calculate the number of seniors paying the supplemental premium surtax by state, we used both the distribution of seniors by state and taxpayers by state. We used seniors by state to take into account that some states, like Florida, have a higher percentage of seniors than other states. We adjusted the figures using taxpayers by state to take into account the relative prosperity of the state population and assumed that this reflected the relative prosperity of the state's senior population.

We first took a percentage of seniors by state for 1986 using the *Current Population Series P-25, 1024,* published by the Bureau of the Census. We then multiplied this by tax returns by state for 1986 from "Individual Income and Tax by State," in the *Statistics of Income Bulletin,* Winter 1987-1988. By summing these results and taking a percentage of the total by state, we now had a percentage that reflected both the distribution of seniors by state and the distribution of taxpayers by state. We calculated the number of seniors paying tax by multiplying this factor times the number of seniors paying the supplemental premium surtax nationwide (see Appendix A). Finally, we calculated the percentage of seniors by state paying the supplemental premium surtax.

SENIORS PAYING MEDICARE SUPPLEMENTAL TAX IN 1989 BY STATE

State	Total No. of Seniors	Seniors Paying Suppl. Tax	Percent
Alabama	527,988	211 245	40
Alaska	19,200	10,198	53
Arizona	438,390	203,961	47
Arkansas	365,858	142,773	39
California	3,044,195	1,474,346	48
Colorado	314,659	152,971	49
Connecticut	449,056	254,951	57
Delaware	76,798	39,335	51
D.C.	81,065	45,163	56
Florida	2,207,948	1,085,364	49
Georgia	647,451	292,830	45
Hawaii	110,931	55,361	50
Idaho	119,464	46,620	39
Illinois	1,477,299	690,553	47
Indiana	700,783	316,139	45
Iowa	443,723	193,763	44
Kansas	353,058	163,169	46
Kentucky	479,989	189,392	39
Louisiana	492,788	180,651	37
Maine	166,396	80,128	48
Maryland	503,455	270,977	54
Mass.	843,713	461,826	55
Michigan	1,107,174	514,273	46
Minnesota	561,053	270,977	48
Mississippi	334,925	118,006	35
Missouri	740,249	337,992	46
Montana	105,598	43,706	41
Nebraska	232,528	106,351	46
Nevada	106,664	56,818	53
N.H.	126,930	69,929	55
N.J.	1,041,042	592,944	57
N.M.	154,663	64,102	41
N.Y.	2,434,076	1,174,232	48
N.C.	779,715	359 845	46
N.D.	93,864	40,792	43
Ohio	1,407,967	655,589	47
Oklahoma	438,390	174,824	40
Oregon	386,124	174,824	45
Pennsylvania	1,846,356	871,205	47
Rhode Island	151,463	77,214	51
S.C.	378,658	160,255	42
S.D.	104,531	43,706	42
Tennessee	628,252	275,347	44
Texas	1,689,560	715,320	42
Utah	142,930	55,361	39
Vermont	68,265	33,508	49
Virginia	645,318	321, 967	50
Washington	554,654	266 606	48
W. Va.	278,393	103,437	37
Wisconsin	665,584	307,398	46
Wyoming	45,866	18,939	41
	31,114,999	14,567,183	

APPENDIX C—METHODOLOGY FOR CALCULATING DISABLED TAXPAYERS

An estimated three million disabled individuals were enrolled in Medicare in 1985. It is more difficult to isolate tax returns by the disabled because there is no special exemption for the disabled as there was for seniors before the 1986 tax reform law. However, IRS does collect information about taxpayers receiving Social Security befits. This data is probably understated because persons with income below the $25,000/$32,000 threshold do not have to report Social Security benefits. We supplemented this data with Census data and found that 18.2 percent of disabled enrollees are taxpayers using the following method.

NUMBER OF DISABLED MEDICARE ENROLLEES REQUIRED TO PAY THE MEDICARE SUPPLEMENTAL TAX

[In millions]

No. of tax returns with Social Security benefits (SOI, 1985, Table 1.4, p. 27)	7.207
Less No. of seniors (age 65 or over) with Social Security benefits (SOI, 1985, Table 2.5, p. 73)	5.698
No. of non-elderly (under age 65) taxable returns with Social Security benefits	1.509
No. of non-elderly persons receiving Social Security benefits (Census, 1988 Current Population Survey, unpublished estimates, 1986, Table 3)	7.944
No. of non-elderly people with Medicare coverage (Census, Receipt of Selected Noncash Benefits 1986, Table 13)	2.878
Percentage of non-elderly Social Security recipients who are on Medicare (2.878/7.944) = 36.2%	
No. of non-elder taxpayers with Social Security benefits who are on Medicare (1.509x36.2%) =	.546,690
Percentage of Social Security disabled taxpayers in 1985 (546,690/3,000,000=.1822) =	18%

APPENDIX D—SUMMARY OF MEDICARE ENTITLED TAXPAYERS

[Percent of Medicare Entitled Taxpayers in 1985]

	Aged	Disabled	Total
Taxpayers	13,361,000	546,690	13,907,690
All	28,536,000	3,000,000	31,536,000
Percent	47	18	44

APPENDIX E—CATASTROPHIC BENEFIT ANALYSIS

	1988–1993 Total	1993 Provisions fully effective
Current law total benefits	$29,686m	$9,807m
New benefits	7,113m (24%)	3,224m (33%)
Medigap equivalent benefits	22,573m (76%)	6,584m (67%)
Medigap duplication	13,995m (47%)	4,060m (41%)
Medicaid duplication	2,257m (8%)	658m (7%)
Newly covered	6,320m (21%)	1,865m (19%)

Source: CBO, ***The Medicare Catastrophic Coverage Act Of 1988: Staff Working Paper,*** August 1, 1988, Table B–2, p. 32. Does not include administrative costs or Medicaid provisions.

EXPLANATIONS

New Benefits—Drug coverage, no 3-day prior stay for NSF, extension of SNF days, no limit on hospice days, home health expansion, respite care, screening mammography.

Medigap Equivalent Benefits—No limit on hospital days, no hospital coinsurance, maximum of one hospital deductible, other technical hospital provisions, maximum deductible of 3 units of blood, copayment cap on Part B services.

Medigap Duplication—According to CBO, approximately 62 percent of Medicare enrollees had medigap insurance. This analysis assumes that 62 percent of "medigap equivalent benefits" duplicate benefits formerly purchased through private insurance.

Medicaid Duplication—According to CBO, approximately 10 percent of Medicare enrollees already were eligible for Medicaid. This analysis assumes that 10 percent of "medigap equivalent benefits" duplicate Medicaid projection. Medicaid also pays for some of the "new" catastrophic benefits, but this was not included because no estimate could be determined.

Newly Covered—According to CBO, approximately 28 percent of Medicare enrollees had neither medigap nor Medicaid protection. These beneficiaries will receive new coverage for these benefits as a result of the catastrophic legislation.

Appendix F
1989 Premium Table

If your tax is:		Then, PREMIUM is:	If your tax is:		Then, PREMIUM is:	If your tax is:		Then, PREMIUM is:	If your tax is:		Then, PREMIUM is:
At least	But less than		At least	But less than		At least	But less than		At least	But less than	
$0	$150	$0	$2,750	$2,800	$416	$5,400	$5,450	$814	$8,050	$8,100	$1,211
150	200	22	2,800	2,850	424	5,450	5,500	821	8,100	8,150	1,219
200	250	30	2,850	2,900	431	5,500	5,550	829	8,150	8,200	1,226
250	300	38	2,900	2,950	439	5,550	5,600	836	8,200	8,250	1,234
300	350	46	2,950	3,000	446	5,600	5,650	844	8,250	8,300	1,241
350	400	54	3,000	3,050	454	5,650	5,700	851	8,300	8,350	1,249
400	450	62	3,050	3,100	461	5,700	5,750	859	8,350	8,400	1,256
450	500	70	3,100	3,150	469	5,750	5,800	866	8,400	8,450	1,264
500	550	78	3,150	3,200	476	5,800	5,850	874	8,450	8,500	1,271
550	600	86	3,200	3,250	484	5,850	5,900	881	8,500	8,550	1,279
600	650	94	3,250	3,300	491	5,900	5,950	889	8,550	8,600	1,286
650	700	101	3,300	3,350	499	5,950	6,000	896	8,600	8,650	1,294
700	750	109	3,350	3,400	506	6,000	6,050	904	8,650	8,700	1,301
750	800	116	3,400	3,450	514	6,050	6,100	911	8,700	8,750	1,309
800	850	124	3,450	3,500	521	6,100	6,150	919	8,750	8,800	1,316
850	900	131	3,500	3,550	529	6,150	6,200	926	8,800	8,850	1,324
900	950	139	3,550	3,600	536	6,200	6,250	934	8,850	8,900	1,331
950	1,000	146	3,600	3,650	544	6,250	6,300	941	8,900	8,950	1,339
1,000	1,050	154	3,650	3,700	551	6,300	6,350	949	8,950	9,000	1,346
1,050	1,100	161	3,700	3,750	559	6,350	6,400	956	9,000	9,050	1,354
1,100	1,150	169	3,750	3,800	566	6,400	6,450	964	9,050	9,100	1,361
1,150	1,200	176	3,800	3,850	574	6,450	6,500	971	9,100	9,150	1,369
1,200	1,250	184	3,850	3,900	581	6,500	6,550	979	9,150	9,200	1,376
1,250	1,300	191	3,900	3,950	589	6,550	6,600	986	9,200	9,250	1,384
1,300	1,350	199	3,950	4,000	596	6,600	6,650	994	9,250	9,300	1,391
1,350	1,400	206	4,000	4,050	604	6,650	6,700	1,001	9,300	9,350	1,399
1,400	1,450	214	4,050	4,100	611	6,700	6,750	1,009	9,350	9,400	1,406
1,450	1,500	221	4,100	4,150	619	6,750	6,800	1,016	9,400	9,450	1,414
1,500	1,550	229	4,150	4,200	626	6,800	6,850	1,024	9,450	9,500	1,421
1,550	1,600	236	4,200	4,250	634	6,850	6,900	1,031	9,500	9,550	1,429
1,600	1,650	244	4,250	4,300	641	6,900	6,950	1,039	9,550	9,600	1,436
1,650	1,700	251	4,300	4,350	649	6,950	7,000	1,046	9,600	9,650	1,444
1,700	1,750	259	4,350	4,400	656	7,000	7,050	1,054	9,650	9,700	1,451
1,750	1,800	266	4,400	4,450	664	7,050	7,100	1,061	9,700	9,750	1,459
1,800	1,850	274	4,450	4,500	671	7,100	7,150	1,069	9,750	9,800	1,466
1,850	1,900	281	4,500	4,550	679	7,150	7,200	1,076	9,800	9,850	1,474
1,900	1,950	289	4,550	4,600	686	7,200	7,250	1,084	9,850	9,900	1,481
1,950	2,000	296	4,600	4,650	694	7,250	7,300	1,091	9,900	9,950	1,489
2,000	2,050	304	4,650	4,700	701	7,300	7,350	1,099	9,950	10,000	1,496
2,050	2,100	311	4,700	4,750	709	7,350	7,400	1,106	10,000	10,050	1,504
2,100	2,150	319	4,750	4,800	716	7,400	7,450	1,114	10,050	10,100	1,511
2,150	2,200	326	4,800	4,850	724	7,450	7,500	1,121	10,100	10,150	1,519
2,200	2,250	334	4,850	4,900	731	7,500	7,550	1,129	10,150	10,200	1,526
2,250	2,300	341	4,900	4,950	739	7,550	7,600	1,136	10,200	10,250	1,534
2,300	2,350	349	4,950	5,000	746	7,600	7,650	1,144	10,250	10,300	1,541
2,350	2,400	356	5,000	5,050	754	7,650	7,700	1,151	10,300	10,350	1,549
2,400	2,450	364	5,050	5,100	761	7,700	7,750	1,159	10,350	10,400	1,556
2,450	2,500	371	5,100	5,150	769	7,750	7,800	1,166	10,400	10,450	1,564
2,500	2,550	379	5,150	5,200	776	7,800	7,850	1,174	10,450	10,500	1,571
2,550	2,600	386	5,200	5,250	784	7,850	7,900	1,181	10,500	10,550	1,579
2,600	2,650	394	5,250	5,300	791	7,900	7,950	1,189	10,550	10,600	1,586
2,650	2,700	401	5,300	5,350	799	7,950	8,000	1,196	10,600	10,650	1,594
2,700	2,750	409	5,350	5,400	806	8,000	8,050	1,204	10,650	and over	1,600

Source:
Department of the Treasury
Internal Revenue Service

Publication 934
December 1988

STATEMENT OF THE NATIONAL EDUCATION ASSOCIATION

Mr. Chairman and Members of the Committee: The National Education Association, representing 1.9 million public education employees, including 95,000 members affiliated with NEA-Retired, strongly urges the Committee to revise the financing of the 1988 Medicare Catastrophic Illness legislation.

Catastrophic Illness Insurance came about as a response by Congress to the economic ravages of chronic illness and other diseases for which the course of treatment is inordinately expensive. Public Law 100-360 was a step in the right direction as far as coverage is concerned, particularly with respect to removing or relaxing limitations on institutional care and in the provision of both preventive screening and prescription drug reimbursement. We are aware that the Federal budget deficit prevented Congress from making an all-out assault on these high-ticket health care problems, but the outcome of last year's legislation is viewed by a substantial number of NEA members as far short of satisfactory.

In particular, our members believe that the establishment of the Catastrophic Illness program should have been accompanied by the enactment of a sound Federal long-term care program. In addition, they believe that PL 100-360 violated the social insurance principles that have traditionally governed Social Security and Medicare, that the legislation is harshly discriminatory against the beneficiaries (since they bear the entire burden of financing), and a bad precedent in the area of health care specifically and in public policy in general. In their view, which has been stated vociferously to us in countless letters and other personal communications, the benefits are far outweighed by the financial burdens that the legislation imposes. They recoil at the idea of a huge increase in the basic Part B premium, accompanied by an income tax surcharge. They are particularly incensed by the idea of a user fee that tries to disguise itself as insurance.

We think these members are absolutely correct in their perception of this program. NEA was one of the few national organizations which fought the financing mechanism for this very reason. But we strongly disagree with proposals to repeal PL 100-360. We must begin by reducing the premiums and/or surcharge to bring revenues and benefits into closer balance. But the fact is that the Medicare system is still in danger of the same kind of shortfall that was experienced in the OASDI program seven years ago. The Congressional response in that case was not to curtail available benefits, but to make new financing arrangements that were generally fair—and in keeping with the principle of social insurance: the sharing by the entire community of a common shared risk.

Applying these principles to the Catastrophic Illness program has led to a variety of proposals.

One has been to place the entire Medicare program under a financing mechanism that relies exclusively on payroll tax revenue. This would be a revolutionary change. While it would spread the burden among the entire community of covered workers, the problem with this solution is that it would sharply increase the HI portion of the FICA tax and—unless simply added to the 7.51 percent total tax—would cut into the reserves of the OASDI trust funds. We believe that a substantial reallocation of the HI and OASDI portions of the FICA tax might be considered a few years down the road, but not until the OASDI reserves have been built up sufficiently to prevent the likelihood of a recurrence of the 1972 shortfall.

Another proposal would continue the traditional policy of financing all of Part B above 25 percent of program costs from general revenues. We think this would be the ideal under normal budget circumstances, but the current deficit is such that the necessary appropriations would be subject to an annual political fight that could seriously undermine the program and public confidence in it.

A more intriguing solution is to combine Medicare Parts A and B and add a new section to meet the urgent need for long-term care of the chronically ill. This program could be financed under a system that would *slightly* reduce the OASDI portion of the FICA tax, *slightly* increase the HI portion, *entirely* remove the wage ceiling from the FICA tax for both employers and employees.

The revenues from such a plan we suggest might not cover the entire cost of the combined Part A-Part B-Longterm Care program. Certain advocates, such as Senators Harkin and Levin, have suggested increasing the marginal tax rate for high-income individuals. This proposal should receive serious consideration.

Until the establishment of a cohesive, universal health care system, which is the only viable complete solution to access, cost, and quality problems, this program and the long-term care legislation that should be part of it, will be expensive. But the provision of catastrophic and long-term coverage is of such urgency that we believe Congress must act on them together—*now.*

We believe, based on numerous polls conducted over the past few years, and on recent developments in health benefit negotiations, that a universal, comprehensive program would be overwhelmingly supported by the American people. We urgently request that the Committee consider our proposal for an interim solution to the inadequacy of benefits currently available and the imbalance of the financing system in present law, and move ahead expeditiously with the development of a full national health care plan.

LAURA WILCOX,
Hearing Administrator,
Senate Dirksen Office Building,
Washington, DC.

I protest the catastrophic health insurance surtax. The taxes this places on senior citizens with low incomes is ruinous. I have worked hard all my life to earn my social security and Medicare and I believe this is very unfair.

I strongly urge you to change this law. Otherwise you will have many unhappy senior citizens dissatisfied with this unfair government tax.

PHYLLIS NICHELIN.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen: The Medical Catastrophic Act of 1998 (CCAP) *must* be amended for the following reasons:

> 1. It does not provide protection against long-term nursing costs, which average $2,500 monthly in the Sacramento area. The possibility that my wife and I may end up in a nursing home, without long-term insurance coverage, concerns me very much. Private coverage is usually too dear or too skimpy.
>
> 2. Thousands of senior citizen retirees who will finance CATCAP are already covered by health plans providing them equal or better benefits. My, and my wife's, hospital and medical costs are *fully* covered by the State of California's Public Employees Retirement System (PERS) plans; however, CATCAP will force us to pay for coverage that we do not need and do not want. As a military retiree, I was forced off the CHAMPUS program when I reached age 65, and subsequently was enrolled in the Medicare program. Either I should be allowed to re-enroll in CHAMPUS or be granted an exception to the CATCAP premium charge.
>
> 3. The funding program for CATCAP is extremely disturbing since 40% of the eligible beneficiaries will be bearing the full cost. It is directed solely against those senior citizens who pay income taxes. And while the $800 cap presently in effect does not sound high, when doubled for a couple it becomes $1,600 and will rise to much higher figures in ensuing years. Take that doubled amount from *one* income and there won't be much left for enjoying the golden years.

In my opinion, CATCAP is the most inequitable legislative act that has been enacted in decades.

Your truly,

RICHARD M. NICHOLS.

NON COMMISSIONED OFFICERS ASSOCIATION OF THE UNITED STATES OF AMERICA

Mr. Chairman. The Non Commissioned Officers Association of the USA (NCOA) is a federally-chartered organization representing noncommissioned and petty officers of the Armed Forces of the United States. Its current membership is approximately 160,000 and representative of all military components, including active duty, reserve, national guard, retirees, and veterans. NCOA's interests include the many personnel issues that affect the wellbeing of its members and their families. It is within this regard that the Association is concerned with the current statutory treatment of retired military personnel and veterans under the Medicare Catastrophic Protection Act of 1988, hereinafter referred to as CATCAP.

The Association has authorized other related organizations to use its endorsement of their verbal statements before this distinguished Committee. Nonetheless, NCOA believes it to be in the best interests of all concerned that its views on CATCAP be submitted in a prepared statement for the record. Hopefully, there'll be no objection to this request.

MILITARY RETIREES

The nation's military retirees and their eligible family members are entitled to medical treatment, care, therapy, hospitalization, and related services, under Chapter 55, Title 10, United States Code. Medical care also includes the availability of most medicines prescribed by either military or civilian physicians. All are accessible at Military Treatment Facilities (MTFs) at little or no cost to the patient.

If MTFs are unavailable, many retirees and their surviving spouses have Medicare supplemental insurance, which is certainly not as expensive as CATCAP. In most cases the supplemental policy also provides a more attractive package.

It is, therefore, puzzling to the majority of retired military families, whose members are or are nearing 65 years of age and older, why they should be compelled to pay for an involuntary program that they may not need or want in the first place. Also confusing is why Congress for years allowed the military departments to commit "free medical care" to their service members if they'd serve 20, 30, or more years of active service, when in fact the law prescribed care only if it was available.

These service members, now retired and now 65 years of age and older, find that after completing their side of the bargain, the government appears to be doing everything possible to renege on its original promise. These military retirees are the ones who fought in World War II, and/or Korea, and/or Vietnam. They are the ones who earned pauper wages during years of active service, went overseas in World War II for the duration, barely managed to physically keep their families together, laid their lives on the line for their fellow citizens, underwent long separations from families, and suffered through all sorts of adverse conditions during a "lifetime" in the military.

NCOA believes that it's only fair and reasonable to offer the CATCAP program to retired military personnel and their eligible family members only on a voluntary basis and at more reasonable cost-sharing rates. If nothing else, this group of deserving Americans should be eligible for a Federal retiree surtax exclusion in a similar manner now offered to retired federal civilian employees.

VETERANS

Like consideration should be given to veterans entitled to free lifetime medical care under Title 38, United States Code, and to other veterans eligible for such care at minimal cost in Department of Veterans Affairs Medical Facilities (DVAMFs).

Veterans are divided into three priority categories for the receipt of treatment in DVAMFs. Category "A" veterans are those with service-connected disabilities. They may receive free treatment, care, therapy, hospitalization, etc., for any medical condition.

Category "B" veterans are those former service members without service-connected disabilities but incomes so limited as to qualify for free services in DVAMFs. Veterans in category "C" do not qualify for free care because their incomes exceed statutory limits. However, they may receive services available in a DVAMF if they pay the facility an amount equal to the Medicare category "B" quarterly copayment.

The requirement for category "C" veterans to make the payment to a DVAMF can produce a dollar-taxation if the veteran is later hospitalized in a civilian facility. He or she pays a second quarterly premium if the hospitalization occurs in the same quarter-year. Forced enrollment of this category of veterans in CATCAP produces a triple-whammy.

CONCLUSION

NCOA strongly recommends that Congress give greater weight to a recommendation that retired military families and veterans be authorized to voluntarily reject enrollment in any or all of the services available under CATCAP if they do not need or want that service(s). Additionally, NCOA recommends establishment of a more reasonable cost-sharing program for each available service under CATCAP.

FOOTNOTE

NCOA also subscribes to the theory that our older citizens should not alone carry the financial burden of the program. CATCAP requires a more reasonable method to share and co-pay costs and development of services that are needed and desired by these citizens (i.e. long-term care).

STATEMENT OF MARTIN ORAM

CATASTROPHIC ILLNESS—THE PROBLEM AND METHOD OF FINANCING

After more than 50 years of social security programs in the United States we find ourselves confronted with the problem of catastrophic illness not covered by the present system. There are two main sources of the problems which have developed at this stage of our society. One is the great advance of medical technology and treatment which has produced increases in longevity with consequent lengthening of the period of coverage and extended medical costs. The other source is the general inflation that has characterized the period and the particularly high inflation found in the costs of medical care.

The extension of social security coverage to include catastrophic illness is a most significant advance in relation to the total social security program. Any such growth in the obligations involved should be given serious study of the benefits conferred, direct and indirect, and the costs should be financed with equity and precision. We should, in these days of high technology, concern ourselves with the incidence of benefits as well as the incidence of taxation.

Catastrophic illness is mainly a problem of the elderly in its incidence of financial and physical cost, but empirically we know that the children of the elderly, relatives and friends are often burdened with these costs until they become the burden of the government through Medicaid. Also, to obtain a true social actuarial system it should be financed by a general tax such as a payroll tax.

In another important aspect the children, relatives and friends would also benefit from the enacted social security coverage by the peace of mind and freedom from responsibility they would receive from such legislation. And they would have the security of knowing that they, too, are covered for catastrophic illness should it happen to them.

There are refinements that can be used in the beginning so that the introduction of the system would be more feasible and equitable. Those over 65 could be taxed for the first few years (say 3 to 5) at a much heavier rate so that their higher risk would be covered more directly. That sector should be limited in estimated costs to the Medicare population as the Medicaid over 65 is not their responsibility but that of the general population. After the initial period it would be ideal to not tax the over-65 population for this specific purpose because their productive years are considered over in terms of economic activity. They should be taxed, however, if they are allowed to receive old-age benefits and are permitted to earn additional income.

So much for the short range of need to finance catastrophic illness. To start the general program of covering catastrophic illness we should need only a small increase in the payroll tax. Due to the high technology available today we could introduce fine-tuned equity by varying the percentage of tax graduated by age brackets, say the under-30, over 30 to under 50, and, finally, over 50, with no tax for that purpose on those 65 and over if they are retired and receiving their social security benefits. If there is a desire to tax income recipients over 65 the real ability lies in their other types of income which are legitimately covered by the income tax.

Those are the positive elements of financing catastrophic illness. Next we need to eliminate certain negative elements in the present catastrophic illness law. While the floor principle is valid in terms of ability to pay, the use of a cap on payments is not compatible with the ability to pay, especially if the cap is placed relatively low in the area to be taxed. The tax on social security benefit 'payments in the present legislation was confined to a small band of middle or lower income recipients in terms of incidence.

It is generally recognized that while the coverage of catastrophic illness is a great step forward, it still does not take care of the largest aspects—nursing home and long-term home care. This great step forward in social security must be studied by a commission of experts in the various fields of experience and knowledge governing the area of social security.

The reason this large problem was by-passed was that it may mean the introduction of a national health service. There is no doubt that a full national health program would reduce duplication of effort and work, but even more important would enable administration to employ close oversight and recognize duplications, unnecessary work, overcharges as they come over the desks of the personnel. Also, many countries have been experiencing national health services for many years and they could provide efficient beginning advice to the United States. We could adapt to our needs and circumstances and even contribute our experience and knowledge as we work into our system.

A great problem of today, even in our private business lives, is to cope with the expanding needs (due to our increasing aged population) and costs (due to the increased costs of the great advances in medicine).

The quality and costs of medical care are problems we should be happy to meet since they reflect longer lives and better standards of living for our population. Moreover the expenditures are wholesome and productive elements in our society and reflect the human condition in the best sense.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Mr. Bentsen: Upon reading, reviewing, investigating and coffering with many on the "Medicare Catastrophic Act of 1988," I have determined it to be highly discriminatory, placing an unusual and burdensome tax upon an unlikely segment of the wiser, if older, population of these United States of America.

Investigation has shown the main thrust ramming the Act through Congress was by the so-called "American Association of Retired Persons;" not only was their endorsement a fraud but the authors are also not above suspect. Such, I and we have concluded cannot have the best interest of our senior citizens, nor of our Nation uppermost in mind. . . . That organization, by it's very own name and actions has proven it's self to be the very epitome of deceitfulness.

My and a few of my fellow citizens adjectives applied to the "Medicare Catastrophic Act of 1988" it seems appropriate to repeat at this juncture; discriminatory, objectionable, hideous, unlikely, odious, ill conceived, ill considered, undemocratic and outright un-American

This letter has not been conceived by some deceitful intermediate, but rather by myself at the grass roots, by grass roots. We implore and admonish you to straightaway RESCIND the "Medicare Catastrophic Act of 1988" in it's entirety. No rationalization, no quibbling no fuss.

REPUDIATE THIS VICE, LIFT THIS SCOURGE FROM OUR BACKS AND RESENTMENT FROM OUR HEARTS!

With my greatest sincerity,

VICTOR E. OTT.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Bldg.
Washington, DC.

Dear Senator Bentsen: This is to inform you that we are opposed to the surtax charge on Senior Citizens, as imposed by the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360).

We ask that you work with other congressmen to repeal the act's surcharge tax.

In a local newspaper story, Representatives Robert Matsui, D-Calif. and Vic Faxio, D-Calif. said they would co-sponsor a bill that would repeal the act's surcharge on Senior Citizens. The bill is H.R. 2547.

Sincerely yours,

MARVIN J. AND ELIZABETH V. PAVLACKY.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen: It seems to me that the Congress has been taken in AGAIN by the special interest groups instead of Congress serving its constituents. This time I am very concerned, as a senior citizen, about the Medicare Catastrophic Act of 1988. I have been a productive citizen during my working years and have prepared for myself supporting retirement. One thing I had not counted on was the fact that I was forced to purchase Medicare Part B at $334.80 a year. My regular medical insurance covers all that Medicare covers, but it seems that I must let the U.S. Government pay part of my bill first and then my insurance company can pick up the rest of the account. And for this privilege I pay an extra $334.80.

Now on top of the $334.80 that the government is imposing, an additional burden is being placed on me because I am 65 years old. A surtax to cover what the Government (Congress) thinks I need in my old age, and it wants me to support the whole system including those who do not pay an added tax. I have protected myself financially (but not with BIG bucks) so that I could enjoy myself and not be a burden to anyone. My Government is going to make me a burden to the Government within a few years if the Catastrophic Act is permitted to stand. AND it will not pay for inhouse care or rest home facilities. AARP sure put one over on the Congress that time!!! They came out smelling like a rose. They now have additional insurance policies to cover what the Catastrophic Act does not cover. GOOD BUSINESS AARP.

I've written my representative and senators but they just pat me on the head and give the impression that they know what is best for me. They will fined out that my vote that helped put them in Congress is no longer available to them. I am just one on a long list of thousands of senior citizens who are unhappy with the treatment we are getting from our elected officials and we want this to STOP now!

As chairman of the Senate Finance Committee you are in a position to register the complaints of us seniors and recommend a change of direction in this unfair piece of legislation. Your support of seniors is vital.

Sincerely,

AUBREY L. PENMAN.

Senator LLOYD BENTSEN,
Senate Finance Committee
Washington, DC.

Dear Senator Bentsen: I am writing to protest the outrageously high and grossly unfair tax to be placed on older Americans, to finance the Medicare "Catastrophic Care" program.

Requiring seniors to pay 100% of the costs of this Government program is unfair! After all, we don't require people with school age children to pay 100% of the costs of public education—all citizens share this burden.

While some coverages included in this legislation are important, they are just not worth what we are being forced to pay.

Most seniors with long-term illnesses need nursing care, either at home or in nursing homes.

But the new "Catastrophic Care" program virtually ignores home care and does nothing at all for long-term nursing home care.

I urge you to re-examine the aspects of the law with an eye to making changes and adopt a Medicare program which covers long-term home care and nursing home care financed by all taxpayers.

Sincerely,

ELMO J. AND JOSEPHINE F. PHILIPP.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee

RE: Medicare/Catastrophic Act

Hon. Senator Bentsen: The question is whether the revenue raised under the Medicare/Catastrophic Act is going to show a surplus of nearly $5 billion from 1989-1993, and should the supplemental premium (surtax) be reduced or eliminated?

The answer is yes and no. Reason and logic tell me that yes, there will be a surplus of nearly $5 billion brought on with this new senior tax, but no, there will be no surplus and there definitely would be a deficit of $4.5 billion or more according to the Health Care Finance Administration if the drug program goes into effect on January 1, 1990.

Let me explain. The only two drugs available beginning on January 1, 1990, will be the immunosuppressive drugs used for organ transplant recipients and "certain antibiotics given intravenous safely at home" for the AIDS patients. Tell me, how many seniors would actually qualify for an organ transplant and would use the immunosuppressive drugs? Isn't it more likely that they would be considered a poor surgical risk?

According to the May edition of Sentry, a monthly publication of the Southeast Michigan Hospital Council, medical costs of people diagnosed with AIDS are expected to grow from $2.5 billion in 1988 to $7.5 billion in 1992 in the United States. The number of new AIDS cases is expected to grow from 88,000 diagnosed in May, 1989, to 114,000 in 1992. As many as 1.5 million have been infected with the virus. Experts say that by 1991 as many as 5 million Americans may be infected. Treating each AIDS case costs $35,000 to $100,000 annually.

To qualify for Medicare/Catastrophic insurance, AIDS patients would have to have been diagnosed with the disease for 29 months. The early diagnosis, the new treatments now available and the new drugs, patients can now live five years or longer. This is why there definitely will be a deficit in the Medicare Catastrophic Drug Trust.

Tell me, how many seniors are sexually promiscuous or I.V. drug users and will get AIDS? Yet the burden to finance the care of AIDS patients falls on the shoulders of seniors exclusively. Yes, it is a devastating disease and we should all be concerned. I have a partial solution. Eliminate the supplemental premium and the drug program. in fact, repeal the Catastrophic Act and restore our Medicare prior to July 1, 1988, and let the private sector finance the AIDS patients through voluntary community involvement such as fund raisers, (presently conducted by Hollywood celebrities), churches, foundations, private grants, voluntary donations and private industry, just to name a few. Then there will be no deficit to Medicare or the Federal general budget.

The worst solution would be keeping the Medicare/Catastrophic Act and shifting the costs to the young.

You Congressmen and women voted in this prescription drug program, perhaps unaware of its huge costs and the impact it places on seniors. I, and hundreds of millions of seniors across the nation, are asking you now to eliminate this catastrophe.

I'm representing seniors in Michigan and across the country, and we are asking you to please represent YOUR constituents and NOT the special interest groups who would benefit and gain millions of dollars per month if this Medicare/Catastrophic Act is not repealed.

Some of the special interest groups that would benefit would be the union and corporate retirement programs as they would be relieved of their promised and contracted obligations to their retirees, thereby shifting the total cost to the retirees.

Also, AARP as the largest direct mail pharmaceutical company will benefit from the Catastrophic drug program payments for drugs according to Joseph A. Califana, Jr., former Health Education Welfare Secretary. Presently, a mail-order supplier charges 50 cents to fill each corporate health plan prescription. Now, with the new Drug Trust program effective January 1, 1990, if it's not repealed, AARP pharmacy will charge the new fee of $4.50 per prescription.

AARP will gain millions of dollars per month. AARP is not truly representing their members as they claim, but their own selfish interests. The most recent survey among AARP members, now that they understand the Medicare/Catastrophic Act, shows 98% are against the Act and want it repealed.

Other special interest groups which will benefit from this Medicare/Catastrophic Act are the major corporations along with the AFL–CIO, which controls the National Council of Senior Citizens, while they get out of their retiree health programs, shifting their responsibilities totally on the shoulders of the seniors.

Lastly, hospitals will gain as any severely disabled younger aged group qualifies for the Medicare/Catastrophic Insurance Act and seniors will pay through their ever increasing premiums as hospital costs keep escalating.

According to a February 24 report by the Institute for Research on the Economics of Taxation, "The expected benefit for the nonaged would be twice that of the elderly."

Also, due to an increase in the hospital deductible of $24 which was enacted with the Catastrophic Act and the so-called "benefit" of a 365 day hospital stay, our private supplemental premium has increased and in some cases as much as 46%.

What percent of seniors would realize that "benefit" of a 365 day hospital stay? Less than 2%. Today the average stay in the hospital is two to seven days. The whole Catastrophic Act was ill-conceived.

WE SENIORS ARE THE LEAST TO BENEFIT AND YET YOU EXPECT US TO CARRY THE MAJOR FINANCIAL BURDEN.

Another reason we seniors would like to have the new Medicare/Catastrophic Act repealed is the supplemental premium (sur-tax) forced upon us. A widow or widower with an adjusted income of only $6,700 would pay this additional sur-tax. A couple will begin paying with an income of only $11,100. To me, that is just above the national poverty level, which is $5,770 for a single person and $7,730 for a couple. Hopefully, you will understand why seniors across the nation are outraged.

Also, the supplemental premium (surtax) is discriminating as it singles out only seniors (a targeted class of people) to pay while all age groups will benefit.

The sur-tax, and it is a tax on an income tax, is unconstitutional.

I contacted IRS and was told it was a tax payable to IRS.

However, Health Human Services tells me it is not a tax, it is a supplemental premium. If it is a supplemental premium, can you tell me why I cannot deduct it as a medical expense, as I do my other supplemental insurance premiums on my income tax? *There is something wrong here.*

Your senior citizen constituents across the nation are outraged and want this new Medicare/Catastrophic Act, with its supplemental premium you voted for, abolished!

PLEASE REPRESENT SENIORS IN YOUR DISTRICT AND NOT THE SPECIAL INTEREST GROUPS, AS THIS ACT IS DISCRIMINATORY AND INFLICTS AN UNFAIR FINANCIAL BURDEN ON THE BACKS OF THE SENIOR CITIZENS.

Sincerely,

VIRGINIA PILURAS.

Dear Senator Bentsen: I am happy to hear that the Senate Finance Committee, chaired by you, will hold hearings on the Medicare Catastrophic Act of 1988, later this month, so am writing to give you our views of this Act.

First of all, the only catastrophic part of this Act is the method of financing. This is an unfair tax on people over 65 and still paying income taxes. It will be imposed on only 45% of Medicare beneficiaries. They will pay their own share plus the rest of the 55% on Medicare who do not pay taxes.

Most of the people paying for this Act get no benefit form it and don't want it. We happen to be retired from U.S. Civil Service and have our own HMO coverage and get nothing from this Act, but will pay the maximum. This means we are paying twice for what we already have.

This method of financing does not address the discrepancy between Civil Service retiree pay full income taxes on his retirement and the Social Security retiree paying no income taxes on his retirement. For example, a couple drawing full Social security plus a taxable income of $10,000 has an income of over $30,000 per year and owes no taxes or no catastrophic tax. The Civil Service retirees on a $30,000 annuity owes taxes of $3,230 plus the catastrophic tax. Is this fair?

I'd like to see this age-means form of taxation repealed. It's taxation without representation or benefits. Once Congress gets the needle in the vein, there will be no stopping until all the blood is gone. Next on the agenda is long-term care of seniors, and with this form of taxation in force, I can see where the funds will come from. Another important factor is that there is no cap on this tax. After 1993, it could double or more, and there should be a limit. Also, what if there is a surplus? It should be used to reduce this tax and not used to balance the budget.

Sincerely,

MR. AND MRS. WM. L. PITTS.

Hon. LLOYD BENTSEN,
Member, U.S. Senate,
Senate Dirksen Building,
Washington, DC.

Dear Senator Bentsen: I am very distressed because of the proposals concerning catastrophic Medicare. The people who will be paying for this are the people who worked and deprived themselves of luxuries, just to get ahead financially a little bit. Like me, these are the people who have provided themselves with supplemental health insurance in most cases, so we won't benefit at all from the catastrophic bill but will pay for people who have shown no concern about getting ahead.

I hope you can help us, as most working people didn't make enough money to afford this and what little we did accomplish will be wiped out.

Sincerely,

CHARLES RADCLIFF.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen: Public Law 100-360—The Medicare Catastrophic Act is not equitable. It should be optional, not mandatory.

There is no doubt that some help must be given those with catastrophic illnesses, but it should not be put on the backs of those on limited incomes who have already provided themselves with supplemental insurance.

Again the middle class will be bearing the brunt. We are expected to bail out banks and businesses that, in most cases, have gone through bankruptcy and then go blissfully on after dropping their losses on the rest of us. Now we are being "whammied" by this new "surtax?"!?

Please rethink your attitude on this matter. We Seniors should not be so selfish as to put this burden on our children and grandchildren, but this Act is unbelievably unfair.

The conscience of the Care and Medical professions and you in politics should be examined for ways to reduce ALL costs.

Very truly yours,

JEAN P. AND BETH RICAUD.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington DC.

Dear Sir: The Medicare Catastrophic Coverage act of 1588 now being subjected to hearings and/or review by your committee in session surely must be deemed by sensible persons to be the pejorative climax of all the ill-advised social experimentations of the socially active Congresses of recent decades.

The elderly victims (euphemistically termed "beneficiaries") are denied even the traditional Hobson's Choice by this act. Presumably we may escape it by dying but in no other way may we avoid its benefices.

Some of us, prudently sensitive to the possible need for extended health coverage in our declining years, took steps to provide for it through private insurance obtained at the price of some personal self-denial in material things during our productive years. We who did this are not exempted from the act but are now subjected to a second indemnity under it, a condition not needed and certainly not affordable,

Many of us during our working years chose to forego certain wage benefits in exchange for enhanced and extended medical coverage at the conclusion of our careers. We too are not now exempted from this act in its suffocating omniscience and we most deeply resent it that we are not.

The sheer monetary encumbrance of this most infamous law is an obscenity of itself. The dollars extracted from the elderly electorate by the law which exempts all but them from its onus will constitute yet another golden hoard to be guarded against the greedy pork-barrellers of this Congress and those who follow at a cost beyond estimate by the responsible members, beyond caring by the imprudent.

Sincerely yours,

RUTH ROBINSON.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Bldg.,
Washington, DC.

Dear Senator Bentsen: I must register my protest against provisions of the Medicare Catastrophic Coverage Act. The bill is too complex and as a catastrophic protection device, it is inadequate. The funding method is extremely inequitable.

The Act has subtle and disturbing philosophic implications that are as serious as the obvious items of inadequacy and unfair taxation of the elderly. No doubt you and your committee members, having had time to reflect on the bad effects of this bill, can also see these problems. I will therefore confine my remarks to a few of the more concrete objections.

The first obvious fact is that catastrophic coverage is NOT provided. It is apparent that the "catastrophic" provisions have boon carefully crafted to cover a very small percentage of the elderly. The Act ignores long-term custodial care which remains the true specter of catastrophe for the elderly.

The second obvious fact is that the bill is to be financed by a tax (not a "premium") on a narrowly defined group—those over age 65 who have enough income to be subject to income taxes. I have heard estimates that members of the taxed group will number about 40% of Medicare beneficiaries. Thus the tax will hit even lower middle class persons who are already living quite frugally.

A third fact is that the drug portion of this act provides that a few of us old people will be subsidizing the very expensive drug bills of younger people who ore drug users, homosexuals and promiscuous heterosexuals with AIDS. Although AIDS can be transmitted to persons not in these classes, most of this problem is the result of voluntary bad choices by these people; it must certainly be clear that those of us who are over 65 are not fooling around in high-risk activities!

Another point I will mention: the tax rate will increase annually and there is no cap beyond 1993. You are certainly aware that government programs never become less expensive, are never really cut-back nor ever eliminated. Studies already indicate that the drug portion of PL 100-360 will have a 5.6 billion deficit by 1993.

If catastrophic taxation is applied to this small group of the elderly now, what will it become if TRUE catastrophic medical coverage is ever adopted?

It is clear that Medicare has now partially become a welfare program financed by an inequitable tax on a small segment of the population. It is no longer an insurance program with actuarily-sound premiums on the entire group.

Certainly, on these points alone, this bad legislation needs repeal or substantial amendment.

Sincerely,

ROY E. ROCKSTROM.

P.S. A note on our personal situation:

My wife and I are both over 70 years of age. I have heart, respiratory and gastrointestinal problems; my wife is a paraplegic as a result of stroke during brain surgery and is dependent upon me for care. Our supplemental insurance premium has increased 297 percent in the past two years and coverage has been cut. Out-of-pocket expense for my personal prescription medication (needed for chronic conditions) will be at least $1200 this year. We also now hire minimal help in order to remain in our own home.

I estimate that 25% to 30% of our gross income this year will go for medical insurance premiums end other medical or medical-related expenses. And one or both of us may at anytime have to go to a custodial care facility at a cost of $2,000 to $5,000 a month. Even then we will still have to pay this surtax since custodial care is not tax-deductible. It will not take long to wipe out our modest savings!

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen : I was pleased to read that you had plans to hold a hearing on CATGAP. I have previously written to our representatives in Congress of our opposition to CATGAP.

This health care coverage act puts the financial burden of paying full costs for catastrophic care squarely on the shoulders of only about 40 percent of older middle-income Americans through an income surtax.

The AARP represents only a small part of American opinion and recently it modified its position.

We hope you will seriously reconsider your view of the act.

Sincerely,

FRANK L. AND MARGARET RYAN.

LAURA WILCOX, *Hearing Administrator,*
Senate Dirksen, Washington, DC.

RE: S. 335: Congressional Budget Hearings and Action on Medicare Catastrophic Coverage Act

I wish to register my opposition to PL 100-360, the Catastrophic Health Care Law, which unfairly imposes a supplemental surtax on our elderly citizens to defray catastrophic health care costs incurred by *all* segments of our society. I strongly support national catastrophic health care legislation, but burdening only one element in our population to achieve this worthy goal is both fiscally unsound and patently unjust. A progressive health care tax on *all* U.S. citizens/residents would more equitably distribute this financial burden and, I suspect, result in greater long-term revenues. Since everyone is subject to catastrophic disease and injury, everyone should contribute to paying the bills!

To this end, I endorse Senator John McCain's bill, S. 355, calling for a moratorium on the further implementation of the Catastrophic Coverage Act.

Sincerely,

ALAN SCHUT.

P.S.: For what it's worth, I'm a 40-year-old liberal Democrat and not usually in sympathy with Senator McCain's political positions. This time he's right and Senator Bentsen is wrong!

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen: I would like to protest the unfairness of the *Medicare Catastrophic Act of 1988,* imposed on senior citizens over 65. By 1993 this act, if signed into law, would impose a surtax of 28 percent. I don't think people realize as yet that as they approach age 65 they, too, will be faced by this confiscatory surtax.

Thank you for considering the impact of this piece of legislation on those of us over 65.

Sincerely,

BETTY SETTLE.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Bldg.,
Washington, DC.

Dear Senator Bentsen: I am writing in opposition to the Medicare Catastrophic Act of 1988.

I am 67 years of age and my wife is 65. We are members of an HMO which provides more benefits than the above noted act. I pay for this myself, along with the standard Medicare premium. I do not need nor want this new program.

I am employed part time to augment income from a note which I hold. I will not have a pension other than social security (which I cannot draw while working) and modest savings.

It is necessary for me to continue to work in an attempt to increase our savings but the income tax situation makes this a losing battle. The new surtax will seriously compound my problem. Maybe it would be better for us to quickly spend our savings, quit work, draw tax free social security, drop our HMO and let the government take care of us. Then, rather than being a productive citizen, I would not pay any tax or social security tax and I would not have to put forth the effort of writing letters.

It is my sincere hope that you and your committee will be able to recommend a program to which more thought has been given and which is more fair than the MEDICARE CATASTROPHIC ACT OF 1988.

Sincerely,

GEORGE SLANE.

STATEMENT OF S.O.S. (SENIORS OPPOSING SURTAX) SUBMITTED BY GLORIA BLUMENTHAL, CHAIR

Please include this Statement and the enclosed Petitions and materials in the public record of the public hearing concerning the Catastrophic Coverage Act to be held June 1, 1989 by the Senate Finance Committee. There are 112 Petitions with approximately *4,000 signatures* of persons residing mainly in Mercer County, New Jersey, with a few from residents of other Counties. The Petitions are Copies of the originals, I hesitate to send the originals, but if the Committee requires them, they are available. The language of the Petitions is important, for it spells out the main reasons seniors feel betrayed and discriminated against by the surtax. Therefore, a blank copy of the Petition is attached to this Statement.

Not as Chairperson of the grassroots S.O.S., but on a personal note, this is how the Act has affected my husband and myself. As former State employees, we purchase the group plan available to State retirees. Recently the State Division of Pensions advised that despite the Medicare Act benefits, our premiums would increase, but would have increased more without the Act. This is not what Congress anticipated. Private insurance rates were supposed to go down, not up. It's not happening, premiums are climbing. Since the Act has no "teeth" to make private insurers comply they shall continue to keep raising their prices. Why did Congress believe that private corporations would limit their profits voluntarily? Especially insurance companies which do not need to disclose their financial investments?

Presently we pay $184 a month for combined Blue Cross/Blue Shield (for hospitalization) and Prudential Major Medical (for Doctor bills and prescription drugs). The latter has a one million dollar maximum, and pays 80 percent of our medications now, after a $100 deductible, not beginning in 1992 as in the Medicare Act, and not after a $650 deductible. We would be foolish to drop this excellent health plan. Indeed we cannot, for one of us has diabetes, and is dependent on various medications. True, we don't need the hospitalization portion because Medicare would cover that, but the Major Medical policy is not available without the Blue Shield/Blue Cross. So despite the fact we neither need or want the new Medicare Act provisions, we must pay for them. *That feels like extortion.*

If our gross income with Social Security is $20,000 and our taxable income is $13,500, in 1989 our Federal tax liability would be $2,000, plus a $300 surtax. In 1990 it would be $2,000 plus $500, and by 1993 $2,000 plus $560. That would put us in a higher tax bracket than the wealthiest in the nation! And to make matters worse, the sky's the limit. The law permits the Health Care Financing Administration to increase the surtax one percent each subsequent year.

By 1993, of approximately $20,000 annual income, (counting Social Security), expenses for medical care would be:

$2200.00	Private insurance, $184 a month
892.80	Medicare Part B $37.20 a month for two
560.00	Surtax
3652.80	Sub-total, but one must add deductibles
150.00	Medicare deductible, $75 each
200.00	Major Medical deductible, $100 each
4002.00	

That would be a huge 20 percent of the total income. but it's more. because one would have to add the 20 percent of Doctor and prescription drug bills that would not be covered!

Congress, *advised improperly by the AARP,* has inflicted a great hardship on millions of middle class seniors on fixed incomes. I recommend that a Congressional Committee examine AARP's tax free designation. Although they say they represent 30,000,000 elderly, 38 percent of their members are between the ages of 50 and 65. (See *Money Magazine's* October 1988 special report titled *The AARP Empire*). How can the IRS continue AARP's tax free designation when their very name is deceptive? The Association of *Retired Persons* includes millions of people in their fifties who are certainly not retired. They sell insurance, money market, trips, prescriptions, rental cars, and other services to these people. Besides their tax-free status, their financial statement indicates they get millions of federal, taxpayer grant dollars each year for "educational purposes." I was under the impression that organizations with tax exempt status are not supposed to lobby for legislation or to elect anyone to public office. I do think it's unethical for this giant broker for Prudential health and Medicare supplemental group policies, and owner of mail order prescription companies, to have paid lobbyists telling Congress what kind of Social Security and Medicare laws seniors want.

Does the Committee realize that the HCFA will sell computers and software to 52,000 pharmacies, and establish regional computer centers (all with seniors' surtaxes) and every prescription purchased by a person eligible for Medicare will be entered in this giant computer system? The explanation in a New York Times article was, how else could HCFA know when someone had reached the $600 deductible, and be eligible for Medicare to pay a portion of the cost? The article said that HCFA had the authority to establish the mega-computer system, and needed no permission from Congress. It appears that Congress has unleashed an expensive, administrative horror. Medicare's method of paying claims is a mess, (ask any senior, or Dr., or hospital). Before they implement the prescription drug benefit benefits, Congress should be involved. The opinion of the seniors I talked to (thousands), was the program has too high a deductible, and for what it gives, it costs far too much.

In closing, I want to ask, does the Committee realize that seniors, and younger people too, are still shocked and disillusioned that their elected officials could do this to them? Over and over again, there was incredulous disbelief when they heard about the special surtax only for them, and a feeling of betrayal when they finally accepted the fact that it was true. The argument repeated by many elected officials and AARP that "I supported the Act, but didn't like the funding mechanism" is not admirable. It signifies a lack of courage to stand up and vote against what is not right, it means "I will use any means to justify the end."

But there is a Bill which would give Congress time to reevaluate the Act, and permit seniors to participate in the process, *S. 335 the "Medicare Catastrophic Coverage Revision Act"*. It will delay, for a year, all provisions of the Act, including the surtax, with the exception of the hospitalization benefit and spousal impoverishment protection. These are parts of the Act seniors think should be preserved. I urge you to support this Bill as a way to revisit the Catastrophic Act. We would applaud such efforts. I thank you for the opportunity to submit this Statement, and the Petitions.

Facts to Help You Convince Congress That The Surtax is an Unfair, Discriminatory Act

There are about 32 million people eligible for Part A of Medicare (hospital benefits). Of this number almost 4 million are disabled individuals under the age of 65, who because of a physical or mental handicap or disease, are also eligible for Medicare. Most of these individuals do not pay income taxes. Of the 28 million elderly eligible for Medicare A benefits, 40 to 45% pay federal income taxes.

In voting for the Catastrophic Coverage Act, Congress imposed on these senior citizens a gigantic tax increase to pay for a massive, new social welfare program, a burden which should be shared by all taxpayers. The Medicare surtax which begins at 15% and rises to 28% by 1993 gives the elderly the highest income tax rates in the country. Those who pay the surtax will in effect pay federal income taxes at rates of 17.2 and 32 percent rather than the current rates of 15 and 28 percent.

The Internal Revenue Service (IRS) will calculate the surtax as follows:

YEAR	RATE	FOR EACH $150 OF TAX LIABILITY	TOP SURTAX	TAX\TAXABLE INCOME
1989	15%	$22.50	$800	$5.333 on $27.300
1990	25%	$37.50	$850	$3,400 on $20,400
1991	26%	$39.00	$900	$3,462 on $20,600
1992	27%	$40.50	$950	$3,519 on $20,800
1993	28%	$42.00	$1,050	$3,750 on $21,650

For example, an individual or couple filing a joint return with taxable income of $13,350 would pay $2,000 in taxes for 1988. The surtax adds $300 to 1989 taxes, $500 in 1990, $520 in 1991, and $560 in 1993. In 1993 seniors will be paying $2,560 to the I.R.S., while other citizens will be paying $2,000 on the same taxable income! A married couple, both eligible for Medicare, pays one surtax added to their income tax liability, however the maximum $1,050 (in 1993) that can be paid by an individual is doubled. (Although the law subtracts the first $150 from income subject to the surtax, the difference is so minimal, we eliminated it).

To date, March 27, 1989, despite anger expressed in many newspaper editorials, and eleven Bills introduced in Congress to repeal or delay the surtax, except for Congressman Chris Smith (R. 4th District including Mercer County and parts of Burlington County, NJ) who has co-sponsored H.R. 63, a Bill to delay the surtax for one year, Senators Bradley and Lautenberg of New Jersey, Senator Spector and Congressman Kostmayer, Pennsyvania, have not responded to their constituents' complaints. They send the same form letters, proclaiming how wonderful the new Medicare benefits are. They, along with Chair of the Senate Finance Committee, Senator Bentsen, and Chair of the House Ways and Means Committee, Congressman Rostenkowski, are pretending the storm of protest about the surtax doesn't exist. Their strategy is to ignore the protests, and stand pat. But some Congressmen have publicly acknowledged the tremendous amount of mail they are receiving protesting the surtax. SO IT IS VERY IMPORTANT FOR YOU TO CONTINUE TO WRITE. Tell your Senators that AARP is not representing your interests. End with a request to delay the surtax, and ask for a response addressing your concerns. ALSO WRITE TO AARP, ask them to lobby Congress again, this time to support seniors' request to rescind or delay the surtax.

ADDRESSES:

Senator Bill Bradley, 731 Hart Office Building, Washington DC, 20510
Senator Frank Lautenberg, 717 Hart Office Building, Washington DC, 20510
Horace B. Deets, Executive Dir. AARP, 1090 K St., N.W., Washington DC 20049

NEWARK STAR LEDGER - FORUM

S.L. 2-21-89

Catastrophic tax hikes

DEAR EDITOR:

Last June our Congress passed a new catastrophic health care law affecting some 32 million Americans. It was signed into law by the President in July. And today the great bulk of these 32 million people are still unaware of the total ramifications of this law and how it will be paid for.

Well, frankly folks—you of senior citizen status who pay income tax of over $150 a year—you are going to be the ones to pay for it. And I don't care how you spell it, slice it or present it—it's a new tax. Our politicians don't think so! Yet it's listed as a tax—a tax for only a select group in our society. This despite our retired President's repeated phrase, "No new taxes," and the new guy on the block who has said, "Read my lips."

This new tax started Jan. 1, 1989, and for every $150 of tax to be paid, you will pay an additional $22.50. So if you're over 65, get out your pencil, divide $150 into your total expected tax to be paid in '89 and multiply the result by $22.50. You'll be shocked! If the total passes $800, that's all you'll pay—if you're single. But if filing a joint return—double it. Yes, that's double it to $1,600.

Now, I've been around this old life for 71 years and have never heard such shocking bureaucratic doubletalk. These political hacks have said that this won't change federal income tax brackets. What kind of convoluted thinking do these people use? If you pay $1,600 more a year to the IRS, this very simply is changing your bracket. The usual smokescreen.

And that's not all, folks. This bite will increase to $37.50 per $150 in 1990 and to $42 in 1993. Now this is not only a tax on a tax, it's confiscation of your hard-earned income that you planned on for many years.

And it establishes a dangerous precedent with our Congress dodging its responsibility for appropriating the funds necessary for the programs it approves. And also, when do we in this country regulate charity by discriminatory taxation laws?

It seems to me that the Boston Tea Party resulted from similar taxation laws and was very instrumental in the thinking that fostered this great country. This law is wrong; it has to be corrected.

George H. Bube,
Union

A 'catastrophic' law

S.L. 2/22/89

DEAR EDITOR:

Thank you for publishing that letter from Victor Picozzi which illustrated what a ripoff of the elderly the Medicare Catastrophic Loss Protection Act really is. I hope The Star-Ledger expresses strong editorial support for the scrapping of this legislation.

Mr. Picozzi recommends that all seniors write their congressmen and senators to have this act reconsidered. I have already done so and here is what happened:

My senator sent me a six-page form letter thanking me for my "concern" about this law and then goes on to say that the Catastrophic Protection Act is a "milestone in our efforts to improve the elderly's access to health care." The correct word is millstone.

Now I understand that form letters are necessary. The legislators can't respond individually to every letter they receive. But the time has come for the assistants to our congressmen to compose a new letter on this subject, show it to the boss and tell him there is an avalanche of dissatisfaction with the present act.

I know the coming session of Congress will be a busy one. If there is no time to prepare a better catastrophic act, then kill the one we now have and try again later.

Adrian W. Fredricks,
Hackettstown

Seniors' 'marriage penalty'

DEAR EDITOR: FEB. 18, 89 Star-Ledger

It might be of interest to examine how the Tax Reform Act of 1986 and the Catastrophic Act of 1988 have affected senior citizens, retired and living on fixed incomes. The following is a case of interest worth examining.

Two senior citizens, a man and a woman who have been going together, decided to get married. Before these "over 65s" were to tie the knot, they were told to examine how this would affect their 1989 federal income taxes. In 1989, individually, both will receive $20,000 pensions and both will collect $6.000 in Social Security. They figured their taxes first separately as singles, and then jointly as married to compare the results.

Figuring their single taxes, each shows a gross income of $20,000, before Social Security. Showing less than $25.000 each, they don't have to add half of their Social Security to their gross. Each takes the standard deduction for a single over 65, which with their personal deduction for 1989 will be $5,750, giving a taxable income of $14.250. Looking up this figure in the tax table gives a tax of $2.141 for each of the senior citizens. To this each adds a 1989 supplementary Medicare surcharge of $293 for a total of $2.434 for each. Combining the two taxes together the total will be $4.868.

Figuring their taxes as married filing jointly, their gross will be $46,000, for now they had to include half their Social Security. Taking the standard deduction for two people over 65 and their 1989 personal exemptions adds up to $10.200. Now their taxable income is $35.800, and the tax table gives a tax of $6.164. To this we add $900 for the 1989 Medicare surcharge for a total of $7,064. The tax difference between filing as a single and filing as married is $2,196, a difference of 45 percent.

The conclusion from all these calculations shows that as senior citizens it pays to stay single and enjoy government tax subsidies. I believe that some of our elected officials, who patted themselves on the back for these changes, should take another hard look at a system that penalizes matrimony.

Forum.

Max Rosenberg,
Parsippany

198 Jan.-26.
Trentonian

Don't Speak for Her

Where does the American Association of Retired Persons come off to say that older people support the Catastrophic Health Insurance Plan passed in 1988?

Nowhere on any member's card does it say that AARP has the right to act on our behalf in Washington. We do not vote in their officers and we do not send in a proxy to vote on any issues. AARP has taken the liberty to set up a self-elected body of officers to carry out policies supposedly in the interest of senior citizens.

✓ AARP.

Who voted in John Rother, AARP's director of legislation and research and public policy? He has the audacity to say that 28 million members support the catastrophic illness program? Did they ever poll their members? On the other hand he contradicts this statement by saying members do not fully understand the aspects of this program. How right he is! With all the paid advertising AARP does, why don't they publicize what this bill is all about? Members and the public will get the full impact when they learn about its unfair, discriminatory and unjust contents.

The Golden Age Club of the Jewish Community Center, Trenton, has formed an activist group to fight for the repeal of this legislation.

Frances R. Flacks

JAN. 25, 89
Trentonian

Opposes New Tax

I am a senior citizen writing of my concern with the new "catastrophic health law." I have a pension, "modest" compared to some, on which I am expected to live for the rest of my days. Lo and behold, when I added up my living expenses for 1988, I found them to be nearly half of my pension, not including food, clothing and other necessary incidentals.

Under the new law, aside from the income tax already withheld from my pension, I will be obligated to pay an additional tax of $765. Some of you "old folks" will pay more, yet most of us will never have need of this plan as we will never see the inside of a hospital.

I belong to the American Association of Retired Persons (AARP), the supposed shepherd and safeguard of "oldsters". I feel this organization did a disservice to its membership by not alerting them that such a "bill" was under legislative consideration and affording us the opportunity to make our views known. Instead, the bill was "sneaked" through, without fanfare, and allowed to become law, without our knowledge. The result: The senior citizen was "shafted" again.

AARP ←

A. Bock

S.O.S. (SENIORS OPPOSING SURTAX)

PETITION:

WHEREAS Congress passed and President Reagan signed into law on July 1, 1988, the Catastrophic Coverage Act; and

WHEREAS the legislation created an unprecedented form of taxation by taxing some citizens over the age of 65 at rates far higher than for any other segment of the population, with the purpose of using the surtaxes collected annually from the 45% of the 28,000,000 elderly taxpayers who pay income taxes, to provide health care for the 55% of elderly seniors, and 4,000,000 non-elderly disabled Americans too poor to pay federal income taxes; and

WHEREAS by so doing, Congress has abrogated the government's responsibilty to provide health care to the poor by shifting the costs of what should be a social welfare program supported by all taxpayers, to the much smaller sub-group of elderly taxpayers described above; and

WHEREAS this legislation unfairly places the expensive medical care of AIDS patients on the elderly, for when individuals with AIDS become eligible for Social Security Disability benefits, they become eligible, after a waiting period, for Medicare, and we believe health care for AIDS patients is another program whose costs should be shared by all taxpayers; and

WHEREAS Congress continues the deception of calling the surtax a "supplementary premium" rather than a tax, even though it is mandatory, IRS will collect it, and it cannot be taken as a medical deduction for IRS purposes; and

WHEREAS the democratic process failed for this law; because the Conference Committee meetings were closed to the public, the "financing method" was not disclosed until after the Conference Report (the final version of the Act) was approved by Congress, too late for meaningful comments, and the House hastily voted on the Conference Report without reading it, it being distributed shortly before the vote, under a Rule permitting only two hours for debate, and no amendments; and

WHEREAS AARP's paid lobbyists urged passage of the law, and as reported in Money Magazine's October, 1988 Special Report on AARP, "The membership has no say in anything that happens", seniors had no say in AARP's decision to support the financing method of the Catastrophic Act, and were not informed about the financing method by Congress, the AARP, or the press, until after the law was signed:

THEREFORE we the undersigned voting citizens of the United States, reaffirming our belief in the fairness of our elected officials and the premise that all citizens are entitled to equal protection under the law, demand a major revision of the Catastrophic Coverage Act of 1988 so that (1) there is complete and permanent removal of the surtax, (2) the related inequities identified above are corrected, and (3) the AARP not be invited to participate on any future Commission concerning this Act.

SIGNATURE:	PRINT NAME:	CITY\STATE\ZIP

Petition Prepared by the Golden Age Club of the Jewish Community Centers of the Delaware Valley. Please return this copy to: Chairperson of S.O.S., Gloria Blumenthal, 23 Dixmont Avenue, Trenton NJ, 08618 - Telephone (609) 882-7773. It will be forwarded to members of Congress.

STATEMENT OF VIRGINIA SPRAGUE, LEGISLATION COMMITTEE CHAIRPERSON CRTA, YOLO DIVISION 83

Because under provisions of the Catastrophic Coverage Act of 1988, financial access to Medicare A benefits is not equitable for state and local government employees who were not covered by social security, I propose that the Act be amended to grant equity in financial access to Medicare A benefits. Such equity would result from setting Medicare A buy-in premiums for non-eligible retirees so that they are comparable in cost to the amount of contributions made by social-security-eligible employees including matching amounts paid by their employers and interest thereon.

Identity of ineligible-for-Medicare-A retirees. Approximately 534,000 Medicare beneficiaries were eligible for Medicare Part B benefits only in 1986 (AARP figures in their publication, "THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988, FREQUENTLY ASKED QUESTIONS ABOUT THE LEGISLATION," p. 11). Among the 534,000 persons not eligible for Medicare A are included such state and local government workers as retirees of the public schools teaching staffs in the 13 states which do not have social security coverage for certificated employees.

Effect of Public Law 100-360 on the status of ineligible-for-Medicare-A retirees. The Medicare Catastrophic Coverage Act continued the financial disadvantage established by the earlier Medicare legislation under which retirees not eligible for Medicare A through social security coverage were charged higher buy-in premiums for Medicare A than social-security-covered employees were charged through their payroll deductions plus interest thereon.

Although Public Law 100-360, SECTION 103, PART A PREMIUM FOR MEDICARE BUY-INS, Subsection (d) of Section 1818 (42 U.S.C. 1395i) as amended, includes a welcome reduction of the Medicare A premium to $156 monthly, it is based on the estimated actuarial value of the insurance. Using figures in the Congressional Budget Office Table 2 supplied on p. 4 of this report, the Insurance Value line can be used to predict the approximate buy-in premium for years 1989-1993 and to observe the annually expected rise in the premium. The Medicare A eligible retiree's premium cost ceased on the day of retirement. Though his/ her supplemental premium will undoubtedly rise, it will also remain lower in cost than the ineligible retiree's buy-in premium. In the five years, 1989–1993, the ineligible retiree will have paid *$11,119* in buy-in premiums. The eligible retiree who made the average payroll tax contribution and who will pay the average amount in supplemental premiums will have paid (according to CBO Table 2) $4,013 in payroll deductions and will pay on the average $820 in supplemental payments, a total of *$4,833.*

Even the enrollee in social security who made the maximum payroll tax contribution and who will pay the maximum supplemental premium in 1989–1993 paid just $7,577 in payroll contributions including matching employer contributions and interest and will pay $4,550 in supplemental premiums in 1989–1993, totaling *$12,127,* little more than the cost of only five years (1989–1993) of non-eligible buy-in premiums. The average non-eligible retiree who retired at age 65 on December 31, 1973, and who had paid all buy-in premiums until December 31, 1988, would have paid $19,956 by December 31, 1988, to receive the same Medicare A benefits which the social-security-covered Medicare A eligible retiree got for a cumulative contribution of $412, the maximum accumulated by a December 31, 1973, retirement date. By 1993 the non-eligible continuing to pay the buy-in premium for Medicare A would have paid $31,075, amounting to 256 percent of Medicare A cost to the maximum payroll tax of the Medicare A eligible retiree.

Chart 1, p. 5, compares Medicare A costs for benefits. Federal legislation established Medicare A as a benefit for employees of private employers but excluded state and local government employers from the responsibility of providing future health care benefits for retired employees and thereby exempted such government employers from the cost of matching employee contributions. The result was that government retirees not covered by social security could not begin to pay for buy-in premiums until after retirement, had no employer matching funds for payments, and were charged the estimated actuarial value of benefits although social security retirees have paid for only a fraction of the actuarial value of lifetime benefits. (See Congressional Budget Office Table 2 on p. 4.)

Recommended amendment. I, therefore recommend and urge that the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360), Section 103, PART A PREMIUM FOR MEDICARE BUY-INS, Subsection (d) of Section 1818 (42 U.S.C. 1395i) be amended as proposed on p. 6, entitled "PROPOSED AMENDMENT OF THE MEDICARE CATASTROPHIC ACT OF 1988 (Public Law 100-360)."

The two effects of the proposed amendment. The effect of the provision "(4) Limitation of Part A Premium" would be to grant the retiree not eligible for Medicare A financial equity in access to Medicare A health care coverage under federal law by requiring from the non-eligible retiree a lifetime premium which would total no more than the premium of an average person of the same age covered by Medicare A through social security. Equating the premium of the non-eligible retiree with the cost to the *average* Medicare A eligible retiree is just because the salaries of such non-eligible government retirees, many of them public school teachers, were not salaries high enough to have required a maximum contribution. Data in regard to these salaries should be available from retirement system records establishing pension amounts.

The effect of the provision "(5) Recognition of achievement of Medicare A eligibility after satisfaction of requirements to establish purchased eligibility" would be to grant to the non-eligible-for-Medicare-A retirees the same treatment which Medicare A eligibles receive under the Catastrophic Act—a premium which is scaled according to income. The supplemental premium for eligibles has been, except for a cap which limits the rate of contributions for the most affluent taxpayers, set so that eligible retirees of lowest tax liability pay least in amount for the supplemental premium (surtax). The buy-in premium is not adjusted to the ineligible's retirement income in any way. The oldest retiree with the smallest pension or the retiree with an ineligible spouse also needing health insurance must either pay the high premium of Medicare A or of a private insurer or go without insurance.

Conclusion. If Congress subsidizes the cost of Medicare A coverage for social security retirees who have been covered by Medicare A for less than the number of years than would be required for these retirees to have contributed enough to pay for full coverage under Medicare A, Congress should supply a subsidy of equal value to the non-eligibles for Medicare A, whose state and local government employers were not required by the Federal Government to provide health care coverage and make contributions toward health care coverage in retirement for their employees.

TABLE 2. ALTERNATIVE PROJECTIONS FOR THE SUBSIDY VALUE OF MEDICARE, 1989-1993
(In dollars per enrollee)

Calendar Years	1989	1990	1991	1992	1993
FOR ENROLLEES WHO MADE THE AVERAGE PAYROLL TAX CONTRIBUTION AND WHO WILL PAY THE AVERAGE AMOUNT IN SUPPLEMENTAL PREMIUMS					
MEDICARE PART A					
Insurance value	1896	2071	2219	2391	2566
- Portion earned by payroll tax (36%) /a/	-683	-746	-799	-861	-924
- Supplemental premiums /b/	-101	-148	-168	-188	-215
= Part A subsidy value	1112	1177	1252	1342	1427
MEDICARE PART B					
Insurance value	1295	1553	1788	2009	2268
- Fixed premiums	-383	-398	-445	-482	-511
= Part B subsidy Value	912	1154	1343	1527	1757
TOTAL MEDICARE SUBSIDY VALUE	2024	2331	2595	2869	3184
FOR ENROLLEES WHO MADE THE MAXIMUM PAYROLL TAX CONTRIBUTION AND WHO WILL PAY THE MAXIMUM SUPPLEMENTAL PREMIUM					
MEDICARE PART A					
Insurance value	1896	2071	2219	2391	2566
- Portion earned by payroll tax (68%) /a/	-1289	-1408	-1509	-1626	-1745
- Supplemental premiums /b/	-800	-850	-900	-950	-1050
= Part A subsidy value	-193	-187	-190	-185	-229
MEDICARE PART B					
Insurance value	1295	1553	1788	2009	2268
- Fixed premiums	-383	-398	-445	-482	-511
= Part B subsidy Value	912	1154	1343	1527	1757
TOTAL MEDICARE SUBSIDY VALUE	719	967	1153	1342	1528
FOR ENROLLEES WHO MADE HALF THE AVERAGE PAYROLL TAX CONTRIBUTION AND WHO WILL PAY NO SUPPLEMENTAL PREMIUMS					
MEDICARE PART A					
Insurance value	1896	2071	2219	2391	2566
- Portion earned by payroll tax (18%) /a/	-341	-373	-399	-430	-462
- Supplemental premiums /b/	0	0	0	0	0
= Part A subsidy value	1555	1698	1820	1961	2104
MEDICARE PART B					
Insurance value	1295	1553	1788	2009	2268
- Fixed premiums	-383	-398	-445	-482	-511
= Part B subsidy Value	912	1154	1343	1527	1757
TOTAL MEDICARE SUBSIDY VALUE	2467	2852	3163	3488	3861

Source: Congressional Budget Office. 25-NOV-88

a. Includes both employee and employer share of payroll tax, as well as interest earnings.
b. Deducted from Part A because liability is based on Part A eligibility.
Receipts, however, pay for new benefits under both Part A and Part B of Medicare.

COMPARATIVE COST OF MEDICARE A HEALTH INSURANCE UNDER PUBLIC LAW 100-360 AND PREVIOUS MEDICARE LAW FOR RETIREES ELIGIBLE FOR IT AND FOR RETIREES NOT ELIGIBLE FOR IT BECAUSE OF LACK OF SOCIAL SECURITY COVERAGE

Expected cost* for Medicare A for retirees eligible for Medicare A through social security who retired on December 31, 1988,

(1) who made maximum payroll tax contributions and who will pay a maximum amount in supplemental premiums for 1988-1993

(2) who made average payroll tax contributions and who will pay an average amount in supplemental premiums for 1988-1993

(3) who made half the average payroll contributions and who will pay no supplemental premiums for 1988-1993

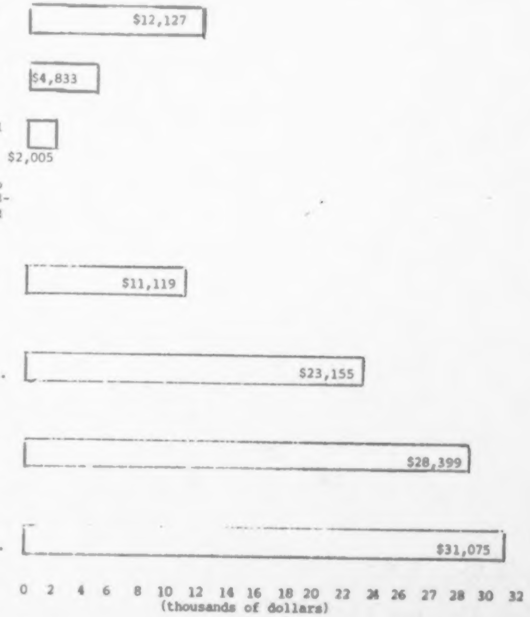
Cost through 1993 for non-eligible-for-Medicare-A retirees, who are not subject to payment of the supplemental premiums for 1988-1993 but who will pay for buy-in premiums based on the projected actuarial value of insurance benefits,

(a) who were 65 and retired on December 31, 1988, and who start in 1989 to pay for Medicare A buy-in premiums for 5 years (ages 65-70). (Those surviving after 1993 will pay an additional premium during each year of life.)

(b) who were 65 and retired on December 31, 1983, and who will pay for Medicare A buy-in premiums for 10 years (ages 65-75). (Those surviving after 1993 will pay an additional premium during each year of life.)

(c) who were 65 and retired on December 31, 1978, and who will pay for Medicare A buy-in premiums for 15 years (ages 65-75). (Those surviving after 1993 will pay an additional premium during each year of life.)

(d) who were 65 and retired on December 31, 1973, and who will pay for Medicare A buy-in premiums for 20 years (ages 65-85). Those surviving after 1993 will pay an additional premium during each year of life.)



*After 1993, eligible retirees with sufficient income will pay a supplemental premium during each year of life.

This chart was prepared by Virginia Sprague, 543 Reed Drive, Davis, CA 95616, phone (916) 753-5280, June 7, 1989.

Chart 1

Sources of data. Cost of insurance value, beneficiary costs to be met by payroll taxes (employee deductions, employer's contributions) and projected supplemental premiums were taken from Congressional Budget Office Table 2, Alternative Projections for the Subsidy Value of Medicare, 1989-1993, November 25, 1988. Cost of buy-in premiums were secured by telephone from the Department of Health and Human Services, Social Security Administration [Phone (916) 551-1000], Social Security handbooks of 1982 and 1979, and for 1972 from 9/12/1988 letter of Joseph W. Westbrook, President, NEA-Retired.

PROPOSED FEDERAL LEGISLATION — March 29, 1989, Revision
Drafted by Virginia Sprague, 543 Reed Drive, Davis, CA 95616 — Phone 753-5280

PROPOSED AMENDMENT OF THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988 (Public Law 100-360)

The provisions stated in the following quotations from the Catastrophic Act are taken from the provisions of HR 2470 as stated in PUBLIC LAW 100-360--JULY 1, 1988, SECTION 103. PART A PREMIUM FOR MEDICARE BUY-INS., Subsection (d) of section 1818 (42 U.S.C. 1395i), which is amended to read as follows:

LAW NOW READS: "(d)(1) The Secretary shall, during September of each year (beginning with 1988), estimate the monthly actuarial rate for months in the succeeding year. Such actuarial rate shall be one-twelfth of the amount which the Secretary estimates (on an average, per capita basis) is equal to 100 percent of the benefits and administrative costs which will be payable from the Federal Hospital Insurance Trust Fund for services performed and related administrative costs incurred in the succeeding year with respect to individuals age 65 and over who will be entitled to benefits under this part during that entire year.

"(2) The Secretary shall, during September of each year determine and promulgate the dollar amount which shall be applicable for premiums for months occurring in the following year. Such amount shall be equal to the monthly actuarial rate determined under paragraph (1) for that following year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

"(3) Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium under this section, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for individuals 65 and older as provided in paragraph (1).".

PROPOSED AMENDMENT: It is proposed that in addition to the above stated Paragraphs in Section 103, Subsection (d), Paragraphs (1), (2), and (3) of section 1818 (42 U.S.C. 1395i), two additional paragraphs be added as follows: (Proposed changes are underscored.)

(4) Limitation on Part A Premium. The maximum lifetime premium required of a non-eligible-for-Medicare-A premium purchaser shall total no more than the lifetime premium of an average person of the same age eligible for Medicare A. The premium of the Medicare-A-eligible person shall be defined as the total of the eligible person's accumulated payroll-tax contributions which are (1) the employee's own, (2) the employer's share, and (3) interest accumulated on the employee's and employer's contributions.

(5) Recognition of achievement of Medicare A eligibility after satisfaction of requirements to establish purchased eligibility. When a person without social security quarters required for Medicare A eligibility has completed premium payments established by (d)(4) as an alternate method of establishing status as a Medicare A eligible citizen, such premium payer shall not be required to pay additional Medicare A premiums but shall be subject to the same payment requirements for the Part B premium, the flat supplemental premium, and the supplemental premium as are imposed upon Medicare A beneficiaries who gained eligibility for Medicare A through the completion of the required minimum number of social security quarters.

Hon. **Lloyd Bentsen**,
Senate Finance Committee,
Washington, DC.

Dear Senator Bentsen: Please register my strong protest to the passage of the Medicare Catastrophic Act of 1988.

In addition to many unfair provisions of the Act, it appears to penalize those of us who sacrificed and saved in their productive years in order to achieve a reasonable amount of financial protection in these our so-called "Golden Years."

I do hope your committee, and Congress, will rethink and do what is right for those of us who have worked so hard to make sure we are financially able to provide for ourselves in our later years.

Sincerely,

Paula B. Stahr.

Dear Senator Bentsen: I am writing in regards to the new Catastrophic Medicare Bill.

It is a dreadful injustice leveled at Senior Citizens only. The majority of us do not spend X amounts of days in the hospital nor do we get AIDS and need such outrageously expensive amounts of prescribed drugs and medical care. Many elderly people do need custodial care and there is a great need for some financial help in that area.

My husband is 68 years old. He is retired from the Military and has served during all of our wars (real and cold) since August of 1941.

We pay taxes now. If the legislators continue to tax us on taxes we will be destitute and on welfare.

Yours truly,

Isabel J. Stevens (Mrs. W.D.).

Senator **Lloyd Bentsen**,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen: I believe senior citizens think that for the most part intelligent and equitable legislation is being enacted.

However, the Catastrophic Health Care Act is a catastrophe for many of us. We, who have planned and saved to insure ourselves of an income above the subsistence level and adequate medical coverage for our retirement years now face a drastic income reduction due to the Catastrophic Health Care Act.

We are being forced to support the medical care of many others, including those individuals whose concept was, "I'll live for today, someone else will take care of me tomorrow."

What kind of message are we sending to the young in our society about saving towards one's retirement years?

Each year, as the percentage rate of this burdensome tax is raised, it will deprive us of more of the little money we have saved, until it is all gone. The time will soon come when there will no longer be a middle class to tax. There will be only the very poor and the very rich.

It is estimated that only 40 percent of those 65 or older have an annual income of $30,000 or more. You, Senator Bentsen, stated that "opposition came from the wealthy not wanting to pay additional premiums."

If $30,000 annual income makes a person wealthy, I suggest that congressional salaries be cut to something less than that amount as taxpayers should not have to pay a wealthy salary. I also suggest that we seniors refuse to vote for incumbents. Those legislators who make a career out of public office to enhance their own prestige, power and wealth.

For the most part the surtax has been glossed over in the 1989 Medicare Handbook.

It discusses only the 1989 surtax which is $22.50 for each $150 of adjusted Federal income taxes. The fact that this amount applies to each Medicare recipient over 65 years old is rarely publicized.

For 1989, a couple over 65 with earnings of $30,000 will be taxed $45 per each of $150 of Federal income tax to a maximum of $1,600.

It is not explained that each year and by 1993 the rate becomes 28 percent per retiree, or 56 percent per couple.

The measure also allows the surtax to increase one percent per retiree or two percent per couple in each succeeding year, Thus, the year 2000, the surtax would 70 percent of the Federal income tax per couple.

Give us a break. We have earned it.

Sincerely yours,

SYLVIA L. TAYLOR.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen: In the Twenties and Thirties during the era of Al Capone, Machine Gun Kelley and Pretty Boy Floyd; There was a time when the Protection Rackets flourished under the control of the gang mobs, Mafia and others. Our F.B.I. and the Treasury Dept. eventually pretty well eliminated the Protection Racket then, only to have it rear it's ugly head again in 1988. The only difference is that this time it is called the Medicare Catastrophic Coverage Act of 1988, (MCCA: Public Law 100-360). An overwhelmingly majority of our senior citizens feel that the MCCA is an up-dated version of the old Protection Racket, because it forces all of the 65+ Seniors to take it and pay for it whether or not we want it or need it

For example, as a retiree from General Motors, my retirement package includes Catastrophic Medical insurance offered by a *public insurance co.* for which I pay only *$12.02* a month deducted from my pension. This is a much better package than offered by Medicare's MCCA, both in coverage and cost. Incidentally, there are probably several hundred thousand other G.M. retirees with the same coverage as well as many other non-G.M. retirees who neither want nor need MCCA, and if given the opportunity would overwhelmingly vote for repeal of MCCA. I am sure this majority will also be voting for their Washington representatives that support repeal of MCCA and/or support of H.R.63 sponsored by Representatives Bill Archer, (Texas), and Rod Chandler, (Washington).

I feel that it is downright unconstitutional to implement a surtax and force me to buy something, that I don't need and don't want, (MCCA Protection), and further that I already have from another source. If that isn't coercion and a form of a protection racket, I don't know what is.

Contrary to the American Association of Retired Person's (AARP) report of support of MCCA by their membership, MCCA is NOT supported by the majority of AARP members affected by the law, (those over 65 who were not included in the survey.)

I am a member of the AARP, am over 65 was not included in their survey and *Do not support MCCA. The AARP has a MediGap Insurance program that handshakes with the MCCA. Is it possible that AARP's support of MCCA has an ulterior motive?*

I feel that the MCCA is an infringement of my right to select what protection I want and from whom I wish to procure it. Also, it is discriminating against one segment of our society and punishing those of us who can't help being 65 years of age or older.

Don't support Protection Racketeering, Represent your constituency, stand up and be counted, vote to repeal MCCA Public Law 100-360.

WILLIAM G. TOLAND.

Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen: Thank you for your letter of July 6th, in reply to mine of June 15th.

In your first paragraph you state the MCCA is in response to the letters you have received over the years from older Americans who have told you how their assets and families have been devastated by medical catastrophes. Also, that these were hard-working Americans who spent their entire lives saving for their retirement, only to find their savings, home and personal possessions threatened and their children burdened by debt.

Now let me apprise you of another fact. There are many thousands of other hard-working Americans like me who have worked cur entire lives and over the years negotiated with our employers to build a retirement program that would see us through our years of retirement. As an example, I pay $12.00 a month through my retirement program for *complete catastrophic coverage including long term care etc. NOT COVERED BY MCCA*. I don't mind paying the extra $4 a month premium charge for MCCA as long as I am not forced into taking the coverage, but I strongly object to the surtax that I have to pay for a coverage that is an inferior duplicate of what I already have.

During my working years I chose to make provisions for this care upon my retirement, now your MCCA is depriving me of my freedom of choice and forcing me to take and pay for something I neither want nor need, since I already have and pay for better coverage. The added cost, (surtax) of MCCA will be depriving me of income that I provided for to maintain a quality of life after retirement. Is this what you want for me and the thousands of other seniors like me.

In our second paragraph, you state that President Reagan and President Bush have both insisted that Medicare enrollees bear the full burden of financing these benefit improvements, (if they can be called an improvement). I also recall president Bush saying, "Read My Lips, No New Taxes." The MCCA surtax would certainly imply that the President is or was a LIAR! Let's make the President an honest man again by eliminating the surtax and making MCCA an option available to and payable by the beneficiaries.

If someone owns an automobile would it be constitutionally fair to force him to buy another so some one without could also get one?? This is analogous to how the MCCA is financed. *It is no different than the old gangster days of the protection racket.*

If the MCCA program is so good, why not make it an optional Part "C" and available to only those who want or need it. Let it stand on it's own feet without tying it to Part "B" or anything else. If the program is not good enough for that, then it should be *scrapped*, instead of forced own everybody's throat.

William G. Toland.

Senator Lloyd Bentsen,
Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Sir: I think you are wrong about the Medicare Catastrophic Act of 1988. It is unfair to selectively tax so few so heavily. Please reconsider your position on this bill.

Yours truly,

Mrs. Adelle Tracey.

Senator Lloyd Bentsen,
Chairman, Senate Finance Committee,
Senate Dirksen Office Building,
Washington, DC.

Dear Senator Bentsen: I highly protest the Medicare Catastrophic Act of 1988, as presently funded. In my opinion, it is unfair to tax the presently proposed who presently pay Federal Income Taxes.

In my opinion the whole field of health care costs needs greater regulating in control of costs. Millions and millions of dollars are paid that are not justified. There will never be enough to satisfy the overpaid providers in many cases—I mean doctors, hospitals, research facilities and on and on.

Your support for the great numbers that protest this present above will he appreciated.

Sincerely,

Raymond Turner.

Hon. LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Bldg.,
Washington DC.

Dear Sir: The Medicare Catastrophic Act is a very bad deal for those of us on a fixed retirement income. It will cost much much more than I can expect to receive in benefits. I feel that tne act was passed to cover the projected costs of treating AIDs patients, both with the long term hospitalization and in a few years the excessive medicine costs. It seems that Congress wants to shift the bill for the nation's welfare costs from the general taxpayers to the elderly tax payers.

By the estimated billions of dollars in over-payments that the sur-tax will bring in, it appears that Congress hoped to reduce the deficit without biting the bullet. All of the seniors that I know are opposed to this act and I strongly urge you to repeal this catastrophic tax on senior citizens.

Sincerely,

WILHELMINA WALLER.

WASHINGTON BUSINESS GROUP ON HEALTH

MARINA WEISS,
Chief Analyst for Health and Human Resources,
Committee on Finance,
Dirksen Senate Office Building,
Washington, DC.

Dear Marina: As you may recall, last year we discussed what WBGH members believe is an inequity in the new Catastrophic Care Law. We believe this could be corrected through a simple technical correction. The following explains the problem.

Under Pre-Catastrophic Care Medicare law, beneficiaries who do not opt into Part B during initial Medicare eligibility are penalized if they later enroll in Part B. The following describes this penalty:

> An individual who fails to enroll during his "initial enrollment period" may enroll thereafter only during a general enrollment period running from January 1 to March 31 every year. If an individual enrolls during a general enrollment period, coverage will not start until the following July, and the monthly premium will be *10% higher than the basic premium for each 12-month period in which the individual could have been enrolled but was not.* 42 C.F.R. 405.213.

The premise of this penalty, no doubt, is tied to the correct assumption that the later a beneficiary enrolls the more expensive he/she will be due to increased age or adverse selection.

Under the new Catastrophic Care law, Part B enrollment remains voluntary however, the premium is not. Therefore, in reality there is a "de-facto" mandatory enrollment. It would not make much sense for those required to pay the new premium to opt out of Part B.

Thus, those who previously did opt-out of Part B will likely want to enroll in light of the new law. However, it appears that these beneficiaries would be penalized for this late enrollment. This is unreasonable in that these beneficiaries are now enrolling due to a change in the law, which is quite a different situation then just opting in late. It seems fair that there should be some period of time in which those currently not enrolled in Part B could do so without penalty. Perhaps a one time opt-in period with a waiver of the penalty could be allowed.

I will be calling you in the next few weeks to discuss this in further detail. I look forward to working with you on this.

Thank you for your consideration.

Sincerely,

CATHY AMKRAUT CERTNER,
Director, Public Policy.

Senator Lloyd Bentsen,
Chairman, Senate Finance Committee,
Senate Dirksen Building,
Washington, DC.

Dear Senator Bentsen: The Catastrophic Medicare Act of 1988 should be rescinded or tabled for further study. The Act in itself is a catastrophe!

The fact that many Senior Citizens already have medigap supplemental and long term skilled nursing care insurance with better coverage obviously was never considered. We should be allowed a choice.

Since I carry the above ($2,157.50), I highly resent the inequitable surtax imposed on my budget to benefit the welfare burden which should be shared by general taxpayers, not by middle class seniors.

The principle of Social Security Medicare should be returned to the affordable rate of 1982 based on cost-of-living allowance and not on the projected raises presented.

Sincerely,

Mrs. Ruth C. Wells.

Senator Lloyd Bentsen,
Chairman, Senate Finance Committee,
Senate Dirksen Office Bldg.,
Washington, DC.

Hon. Sir: According to the media, you have started hearings on the Medicare Catastrophic Act of 1988, and we Medicare recipients should express our views to you and the committee before June 22nd.

I will try to be brief in my remarks.

1. In a news item you were quoted to the effect that the estimates of the funds raised so far exceeds by ten billion dollars, the original estimate, and some correction be made. It has not been made clear just where these funds will go.
2. We hear that the "progressive system of hospital reimbursement" allows hospitals to discharge patients too soon, since they can retain these fees, for the days saved through early discharge. No one should be paid for such a profit from services not rendered.
3. No one understands just what "catastrophic illness" means, since only one-tenth of recipients would be affected.
4. Congressman Shumway defines this is a discriminatory tax against those who can afford it the least. It seems clear to me this is unconstitutional.
5. Under the Reagan administration, a "Medicare Czar" was appointed (an ex-executive of Blue Shield). It seems that Blue Shield is running the show, and I understand they administer the payments to the Providers, resulting in many new Providers of service have struggled to get a slice of the "Medicare Pie", e.g. many physician groups setting up "clinics" outside of their regular practices.

Perhaps the time has come for Socialized Medical care. Reports from other countries have successful programs. It is time to move in a new direction! More corporate taxes are needed. They can afford it.

Very sincerely,

E.A. Wichert.

Senator Lloyd Bentsen,
Chairman, Senate Finance Committee,
Senate Dirksen Office Bldg.,
Washington, DC.

We, as senior citizens, are incensed over the tax on a limited segment of the population to pay for catastrophic Medicare for all.

John T. and Mildred Willoughby.

Senator LLOYD BENTSEN,
Chairnan, Senate Finance Committee,
Senate Dirksen Office Bldg.,
Washington, DC.

Dear Sir: This letter is in protest of the new catastrophic health law that was shoved through the Senate and Congress last year before giving the ordinary citizen an opportunity to know what it was all about. That law benefits only a very small number of people, who could be helped better some other way, and is paid for by another small number of people who through no fault of their own are over 65. Most elderly people have taken care of their own needs by having their own supplemental policy. This new bill causes a burden on that group by making them pay up front for doctor bills before Medicare kicks in, then Medicare premiums are higher and they still need the supplemental insurance. To top that all off they then must pay a SURTAX on their tax returns of up to $1,600 per couple for this year. The tax goes up every year. This is unfair taxation on just one group of people to benefit a very few. The whole thing smells of a new way to fatten the Medicare fund so it can be skimmed to pay for some congressman's pork barrel. My opinion is that the whole law should be shelved.

Sincerely,

WANDA WOMACK.

Hon. Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Bldg.,
Washington, DC,

Dear Senator Bentsen: Thank you for your April 27 letter which for some reason I did not receive until May 22, 1989. I am pleased also to learn of your belated concern about the surtax provisions of the Medicare Catastrophic Coverage Act. On the same day of receipt I learned indirectly also that a hearing had been scheduled for June I. Since I am unable to attend the hearing on such short notice, I am writing this letter **with the request that it be entered into and be made a part of the official records of the hearing.**

For hundreds of thousands of California State and local governmental retirees like myself who already have Medigap insurance furnished by their former employers, and which surpass the benefits provided under the MCCA, **the surtax is an unfair and inequitable financial burden thrust upon us.** The benefits we already have are the result of good faith bargaining over the years and the loss of other forms of remuneration that we might otherwise have opted for in lieu of retirement health insurance. **The MCCA is something we did not ask for; did not need; nor did not want.**

For the same reasons expressed above, many retired military **already entitled to lifetime medical care** are being subjected to this unfair tax merely because they qualify for Part A Medicare benefits earned during World War II service and later peacetime employment. I might add also that the so-called "governmental exclusion clause" (Sec. 422 of the Act) applies only in a limited number of cases. It reduces taxable income (for the purpose of computing the surtax) only to the extent that the exemption amount or the retiree's annuity (whichever is the lesser) exceeds any social security income the retiree and/or his spouse may receive. The exemption amount is $6,000 for singles and $9,000 for married couples.

With respect to the surtax method of financing—it is a distinct departure from all former traditional means of Medicare financing. An estimated 40% or more of all eligibles are being forced to subsidize the other 60% **who do not even pay income tax! That is outrageous!** I am not opposed to helping the needy, but traditionally such forms of public charity have been financed over a general tax base—not loaded onto a narrow segment of elderly middle fixed income taxpayers.

The income tax structure also is not an equitable means of determining how much one should pay for health insurance. It does not take into consideration the many ways taxable income can be legally adjusted, nor such extraordinary personal obligations for the care of elderly and/or disabled relatives which cannot be taken as income tax deductions. Because of the cap, the wealthy pay a much smaller percentage of their total income than those of modest means.

Furthermore, for the computation of health insurance premiums, the tax structure treats **widows, widowers, and other singles unfairly** as compared to married couples. For example, in 1989, a single taking the standard and personal deductions will pay the maximum $800 surtax with an adjusted gross income of $33,510. A married couple with the same income will pay only $520 or $260 per person! The married couple would need an adjusted gross income of $62,865 before paying the same per person as the single. In 1990 when the surtax rate increases to 25%, the inequity will be further compounded.

Notwithstanding the above examples, I am opposed to the Act because I believe the benefits are minimal as compared to the cost.

(1) The hospital benefits are mainly sales talk because only a small percentage will benefit. The average annual hospital stay is less than seven days and most hospitals are paid by Medicare on a "Prospective Payment Plan" and not on the actual number of hospital days incurred.

(2) Multiple hospital entries in the same year are relatively few.

(3) The cap on doctor expense is ineffective in limiting doctor expense charged in excess of what Medicare will pay.

(4) The Act conflicts with California community property laws with respect to the espousal impoverishment provisions.

(5) The prescription drug program is an expensive sideline that will benefit relatively few. Furthermore, it is programmed to limit the number that will benefit in future years.

(6) Such benefits as mammographs are not catastrophic cost items. They should be included as preventive diagnostic medical care under the regular Medicare program.

(7) Because of the inequitable financing provisions, the Act is actually a form of income redistribution among the elderly.

In summary, I must ask the question: **Why do we limit catastrophic medical benefits only to those who are eligible for Part A Medicare benefits?** What about the millions of Americans, young and old, who are not eligible for Medicare and who are either uninsured, underinsured, or uninsurable? It is my frank opinion, Senator, that the MCCA does not adequately meet the needs of all citizens in this country. **If we are to have some kind of National health care program,** it should be available to everyone, with the cost for those who cannot afford it paid from general broad-based taxes, the same as with other forms of public assistance. For those who can afford it, the program should be optional and **the premiums should be uniform for those who choose to participate.**

And as a final note—many of we Seniors here in California **do not agree with the views expressed by the American Association for Retired Persons** regarding the Medicare Catastrophic Coverage Act. We do not consider the Association to be a reliable legislative advocate for us. We believe also that these hearings should be held regionally as well as in Washington so that Congress might get a better perspective of how most Seniors really feel about this Act. Once again, thank you for allowing me to express my views and thoughts on this important issue.

Sincerely,

EARL F. WORLEY.

Hon. Senator LLOYD BENTSEN,
Chairman, Senate Finance Committee,
Senate Dirksen Office Bldg.,
Washington, DC

Dear Senator Bentsen: I am writing this letter with the request that it be entered into and made a part of the official records of the Senate Finance Committee hearing which was held on June 1, 1989.

The surtax is an unfair and discriminatory method of financing the Medicare Catastrophic Coverage Act of 1988—for the following reasons:

(1) Although the system **purports** to be based on ability to pay, it makes no allowances for extraordinary living expenses that cannot be taken as income tax deductions—such as, transportation, food, and housing in **high cost living areas,** and the extra costs associated with the caring of aged and/or disabled relatives that some taxpayers must assume. Nor does it make adjustments for those with sizable amounts of non-taxable income and interest deductions for home equity loans, sometimes negotiated primarily for the purchase of luxury items.

(2) It discriminates **between** beneficiaries who pay income tax and those who do not, whereby more than 40% are required to pay approximately 63% of the program cost.

(3) It discriminates **among** those subject to the surtax, whereby **widows, widowers, and other singles** in certain income ranges pay **more per person** than married couples; and the wealthy pay no more than middle income taxpayers paying the maxi-

mum! These inequities are illustrated in the enclosed exhibits which are attached to and made a part of this letter.

Thank you for allowing me this opportunity to express my views and thoughts on this important issue.

Sincerely,

EARL F. WORLEY.

Enclosures.

ANALYSIS OF INEQUITIES IN FUNDING MECHANISM

1989 MEDICARE CATASTROPHIC COVERAGE INSURANCE PREMIUMS

SINGLES	COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	LINE
ADJ. GROSS INCOME	5,850.00	33,510.00	33,510.00	500,000.00	-----1
LESS STD. DEDUCTION	-3,850.00	-3,850.00	-3,850.00	-3,850.00	-----2
LESS PERS.DEDUCTION	-2,000.00	-2,000.00	-2,000.00	-2,000.00	-----3
TAXABLE INCOME	0.00	27,660.00	27,660.00	494,150.00	-----4
INCOME TAX LIAB.	0.00	5,333.30	5,333.30	138,922.00	-----5
CATASTROPHIC MED TX					
SOC.SEC.DEDUCTIONS	48.00	48.00	48.00	48.00	-----6
SURTAX (15% TX LIAB	0.00	800.00	800.00	800.00	-----7
TOTAL MED.PREMIUMS	48.00	848.00	848.00	848.00	-----8

MARRIED FILING JTLY	COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	LINE
ADJ. GROSS INCOME	10,400.00	33,510.00	62,864.80	500,000.00	-----9
LESS STD. DEDUCTION	-6,400.00	-6,400.00	-6,400.00	-6,400.00	----10
LESS PERS.DEDUCTION	-4,000.00	-4,000.00	-4,000.00	-4,000.00	----11
TAXABLE INCOME	0.00	23,110.00	52,464.80	489,600.00	----12
INCOME TAX LIAB.	0.00	3,466.50	10,666.64	138,208.00	----13
CATASTROPHIC MED TX					
SOC.SEC.DEDUCTIONS	96.00	96.00	96.00	96.00	----14
SURTAX (15% TX LIAB	0.00	519.98	1,600.00	1,600.00	----15
TOTAL MED. PREMIUMS	96.00	615.98	1,696.00	1,696.00	----16

SINGLES AND MARRIED COUPLES WITH NO INCOME TAX LIABILITY WILL PAY THE SAME AMOUNT PER PERSON FOR CATASTROPHIC COVERAGE. (COMPARE LINES 8 AND 16 IN COLUMN 1)

SINGLES AND MARRIED COUPLES, BOTH AT THE SAME ADJUSTED GROSS INCOME OF $33,510, WILL PAY DIFFERENT AMOUNTS PER PERSON. A SINGLE WILL PAY $848, WHEREAS THE MARRIED COUPLE WILL PAY $615.98 OR ONLY $307.99 PER PERSON (COMPARE LINES 8 AND 16 IN COLUMN 2)

THE MARRIED COUPLE WOULD NEED AN ADJUSTED GROSS INCOME OF $62,865 BEFORE THEY WOULD PAY THE SAME PER PERSON AS THE SINGLE AT $33,510 (COMPARE LINES 8 AND 16 IN COLUMN 3)

THE SINGLE AT THE ADJUSTED GROSS INCOME OF $33,510 WILL BE PAYING 17 AND 2/3 TIMES AS MUCH FOR COVERAGE AS THE SINGLE THAT HAS NO TAX LIABILITY. (COMPARE COLUMNS 1 AND 2 ON LINE 8)

THE MARRIED COUPLE AT THE ADJUSTED GROSS INCOME OF $62,865 WILL ALSO BE PAYING THE SAME 17 AND 2/3 TIMES AS MUCH AS THE MARRIED COUPLE WITH NO TAX LIABILITY. (COMPARE COLUMNS 1 AND 3 ON LINE 16)

THE SINGLE WITH AN ADJUSTED GROSS INCOME OF $500,000 WILL PAY NO MORE THAN A SINGLE WITH ONLY $33,510. (COMPARE COLUMNS 3 AND 4 ON LINE 8)

THE MARRIED COUPLE WITH AN ADJUSTED GROSS INCOME OF $500,000 WILL PAY NO MORE THAN A MARRIED COUPLE WITH ONLY $62,865. (COMPARE COLUMNS 3 AND 4 ON LINE 16)

NOTE: ALL INCOME TAXES HAVE BEEN COMPUTED IN ACCORDANCE WITH 1989 INDEXED RATE SCHEDULES (NOT TABLES). STANDARD AND PERSONAL EXEMPTIONS ARE FOR THE SAME TAX YEAR - APPLICABLE TO NON-BLIND TAXPAYERS 65 YEARS OF AGE OR OLDER.

Prepared 6/4/89 by Earl Worley - 1836 Maryal Drive, Sacramento CA

ANALYSIS OF INEQUITIES IN FUNDING MECHANISM
1990 MEDICARE CATASTROPHIC COVERAGE INSURANCE PREMIUMS

SINGLES	COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	LINE
ADJ. GROSS INCOME	5,850.00	26,605.30	26,605.30	500,000.00	-----1
LESS STD. DEDUCTION	-3,850.00	-3,850.00	-3,850.00	-3,850.00	-----2
LESS PERS.DEDUCTION	-2,000.00	-2,000.00	-2,000.00	-2,000.00	-----3
TAXABLE INCOME	0.00	20,755.30	20,755.30	494,150.00	-----4
INCOME TAX LIAB.	0.00	3,399.98	3,399.98	138,922.00	-----5
CATASTROPHIC MED TX SOC.SEC.DEDUCTIONS	58.80	58.80	58.80	58.80	-----6
SURTAX (25% TX LIAB	0.00	850.00	850.00	850.00	-----7
TOTAL MED.PREMIUMS	58.80	908.80	908.80	908.80	-----8
MARRIED FILING JTLY					
ADJ. GROSS INCOME	10,400.00	26,605.30	49,055.30	500,000.00	-----9
LESS STD. DEDUCTION	-6,400.00	-6,400.00	-6,400.00	-6,400.00	----10
LESS PERS.DEDUCTION	-4,000.00	-4,000.00	-4,000.00	-4,000.00	----11
TAXABLE INCOME	0.00	16,205.30	38,655.30	489,600.00	----12
INCOME TAX LIAB.	0.00	2,430.80	6,799.98	138,208.00	----13
CATASTROPHIC MED TX SOC.SEC.DEDUCTIONS	117.60	117.60	117.60	117.60	----14
SURTAX (25% TX LIAB	0.00	607.70	1,700.00	1,700.00	----15
TOTAL MED. PREMIUMS	117.60	725.30	1,817.60	1,817.60	----16

SINGLES AND MARRIED COUPLES WITH NO INCOME TAX LIABILITY WILL PAY THE SAME AMOUNT PER PERSON FOR CATASTROPHIC COVERAGE. (COMPARE LINES 8 AND 16 IN COLUMN 1)

SINGLES AND MARRIED COUPLES, BOTH AT THE SAME ADJUSTED GROSS INCOME OF $26,605,WILL PAY DIFFERENT AMOUNTS PER PERSON, A SINGLE WILL PAY $908.80 WHEREAS THE MARRIED COUPLE WILL PAY $725.30 OR ONLY $362.65 PER PERSON (COMPARE LINES 8 AND 16 IN COLUMN 2)

THE MARRIED COUPLE WOULD NEED AN ADJUSTED GROSS INCOME OF $49,055 BEFORE THEY WOULD PAY THE SAME PER PERSON AS THE SINGLE AT $26,605 (COMPARE LINES 8 AND 16 IN COLUMN 3)

THE SINGLE AT THE ADJUSTED GROSS INCOME OF $26,605 WILL BE PAYING 15.45 AS MUCH FOR COVERAGE AS THE SINGLE THAT HAS NO TAX LIABILITY (COMPARE COLUMNS 1 AND 2 ON LINE 8)

THE MARRIED COUPLE AT THE ADJUSTED GROSS INCOME OF $49,055 WILL ALSO BE PAYING THE SAME 15.45 AS MUCH AS THE MARRIED COUPLE WITH NO TAX LIABILITY. (COMPARE COLUMNS 1 AND 3 ON LINE 16)

THE SINGLE WITH AN ADJUSTED GROSS INCOME OF $500,000 WILL PAY NO MORE THAN A SINGLE WITH ONLY $26,605. (COMPARE COLUMNS 3 AND 4 ON LINE 8)

THE MARRIED COUPLE WITH AN ADJUSTED GROSS INCOME OF $500,000 WILL PAY NO MORE THAN A MARRIED COUPLE WITH ONLY $49,055. (COMPARE COLUMNS 3 AND 4 ON LINE 16)

NOTE: ALL INCOME TAXES HAVE BEEN COMPUTED IN ACCORDANCE WITH 1989 INDEXED RATE SCHEDULES (NOT TABLES). STANDARD AND PERSONAL EXEMPTIONS ARE FOR THE SAME TAX YEAR - APPLICABLE TO NON-BLIND TAXPAYERS 65 YEARS OF AGE OR OLDER. (1990 RATES AND EXEMPTIONS WERE NOT AVAILABLE AT THE DATE THIS ANALYSIS WAS PREPARED)

Prepared 6/4/89 by Earl Worley - 1836 Maryal Drive, Sacramento CA

Senator LLOYD BENTSEN,
Senate Finance Committee,
Senate Dirksen Office Building,
Washington DC.

Dear Senator Bentsen: The Medicare Catastrophic Coverage Act of 1988 will be a disaster to those of us over 65 and living on a modest retirement income. It will take what little discretionary income we have to pay a tax that is purely and simply discriminatory. Those of us who have had the foresight and have sacrificed to obtain Medicare supplemental insurance will never qualify for any benefit from this damnable act. Request immediate action be taken toward total repeal of the act. Please do not modify it in an effort to "pull the wool over our eyes" again while leaving the onerous surtax intact.

It would appear that a great opportunity exists for Congress people to show some statesmanship and gain some much needed respect, rather than continued disesteem, from the general public.

Sincerely,

LAWRENCE A. AND SAMMIE J. WREYFORD.

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